



MONO COUNTY
EMERGENCY MEDICAL CARE COMMITTEE



Mammoth Hospital
ED Lounge/Conference Room

July 26, 2011
9:00 a.m.

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF MINUTES

MAY 24, 2011

JULY 1, 2011

ACTION

III. ICEMA UPDATE

- A. Legislation Update
- B. Data System RFP
- C. Paramedic Scope of Practice
- D. Upcoming CQI Project - Pediatric Intubation

INFO/ACTION

IV. EMS SYSTEM MANAGEMENT REPORTS

- A. Scantron Reports
- B. Base Hospital Report

INFO/ACTION

V. OLD BUSINESS

- A. Town of Mammoth Lakes AED Program
- B. Status of CHP Waiver
- C. EMCC Annual Report
- D. MTWC/Mutual Aid Agreement
- E. Other

INFO/ACTION

VI. NEW BUSINESS

- A. AEMT Program
- B. Mono Policy Clarification for Protocol Reference #s:
 - 1. 6100 Stroke Receiving Centers
 - 2. 8100 Continuation of Trauma Run
 - 3. 11110 Stroke Treatment Policy
- C. Countywide MCI Protocol
- D. Inyo County Status for MCI Training
- E. General Protocols
 - 1. 1040 Requirements for EMT -P Accreditation
 - 2. 1060 Certification Accreditation Review Policy
 - 3. 3010 Annual Review Class (ARC)

ACTION/APPROVE

4. 5030 Procedure for Adoption of Protocols and Policies
 5. 6030 AED Service Provider Policy - Public Safety
 6. 6040 Lay Rescuer AED Implementation Guidelines
 7. 7030 Controlled Substance Policy
 8. 8030 Burn Destination and Criteria Policy
 9. 8060 San Bernardino County Requests for Hospital Diversion Policy
 10. 8080 Bed Delay Patient Destination Policy
 11. 9110 Treatment of Patients with Airborne Infections and Transport Recommendations
 12. 10060 Needle Thoracostomy
 13. 10070 Needle Cricothyrotomy
 14. 10110 Transcutaneous Cardiac Pacing
 15. 10120 Synchronized Cardioversion
 16. 10130 Automatic External Defibrillation (AED)-BLS
 17. 11020 Airway Obstruction - Adult
 18. 11040 Bradycardias - Adult
 19. 11050 Tachycardias - Adult
 20. 11060 Suspected Acute MI
 21. 11070 Cardiac Arrest - Adult
 22. 11090 Shock (Non-Traumatic)
- F. Advanced EMT Protocols
1. 7010 AEMT ALS and BLS, Standard Drug and Equipment List
 2. 9010 AEMT General Patient Guidelines
 3. 9020 AEMT Physician on Scene
 4. 9030 AEMT Responsibility for Patient Management
 5. 9040 AEMT Reporting Incidents of Suspected Abuse Policy
 6. 9050 AEMT Organ Donor Information
 7. 9060 AEMT Local Medical Emergency
 8. 9070 AEMT Applying Patient Restraints Guidelines
 9. 9080 AEMT Care of Minors in the Field
 10. 9090 AEMT Patient Refusal of Care Guidelines – Adult
 11. 10010 AEMT King Airway Device (Perilaryngeal) – Adult
 12. 10020 AEMT King Airway Device (Perilaryngeal) – Pediatric
 13. 10130 AEMT Automatic External Defibrillation (AED)
 14. 10160 AEMT Axial Spinal Stabilization
 15. 10160 AEMT Axial Spinal Stabilization
 16. 11010 AEMT Respiratory Emergencies – Adult
 17. 11020 AEMT Airway Obstructions – Adult
 18. 11030 AEMT Non-traumatic Hypertensive Crisis
 19. 11060 AEMT Suspected Acute MI
 20. 11070 AEMT Cardiac Arrest – Adult
 21. 11080 AEMT Altered Level of Consciousness/Seizures – Adult
 22. 11100 AEMT Burns – Adult
 23. 12010 AEMT Determination Of Death on Scene
 24. 12020 AEMT Withholding Resuscitative Measures
 - EMSA Do Not Resuscitate (DNR) Report Form
 - ICEMA Do Not Resuscitate (DNR) Report Form

VII. OTHER/PUBLIC COMMENT

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

IX NEXT MEETING DATE AND LOCATION

X. ADJOURNMENT

The Mono County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and office is located at 515 North Arrowhead Avenue, San Bernardino, CA



MONO COUNTY EMCC MEETING

Mammoth Hospital
A/B Conference Room
Mammoth Lakes, CA

MINUTES
May 24, 2011

Committee Members	Affiliation
<input checked="" type="checkbox"/> Mark Mikulicich	Mono County Paramedic Rescue Chief
<input checked="" type="checkbox"/> Dr. Rick Johnson, MD	Mono County Health Officer
<input checked="" type="checkbox"/> Bob Rooks	Mono County Fire Chief's Association
<input checked="" type="checkbox"/> Lori Baitx, RN	Mammoth Hospital
<input checked="" type="checkbox"/> Rosemary Sachs, RN	Mammoth Hospital

Other Attendees	Affiliation
Ray McGrale	Mono County EMS
Paul Easterling	ICEMA EMS Specialist
Steve Patraw	Boundtree Medical

I. CALL TO ORDER

The meeting was called to order at 9:14 a.m.

II. APPROVAL OF NOVEMBER 10, 2010 MINUTES

Motion to approve by Dr. Johnson, second by Bob Rooks. All in favor with none opposed.

III. ICEMA UPDATE

A. QI plan

QI Plan was previously approved by the State and to the CCQI (Central QI Committee) which met and developed a template. ICEMA will develop indicators that they want, and providers can do the same to best fit their QI objectives. This should be completed in June. Sherri Shimshy should be contacted with any questions.

B. Intubation CQI Project

Pediatric intubation is still a hotbed topic within the Committee; some opposed and some in favor of retaining the skill. It is possible that ICEMA will retain the skill, but additional measures would probably be included in the protocol such as mandatory capnography, etc. Naso-Trach will probably go by the wayside as it is a very low-use procedure. PEDI intubation is also relatively "low-use" but it is

still considered valuable, and is successful in a high percentage of cases. Perhaps part of the solution will be more consistent and frequent training.

C. Data System RFP

There was almost a week-long workshop several weeks back, in which several different companies presented their products. On preliminary findings, ICEMA is most interested in products from Image Trend; however it will require approval from the Board of Supervisors. It could be a year or so before all the details are worked out. The software is compatible with most ECGs, Tough Books, I-Tablets, etc.

IV. EMS SYSTEM MANAGEMENT REPORTS

A. Scantron Data

There were several runs by M-7 that appeared to exceed fifty (50) minutes in response time, and Ray was going to check those out for report back to the committee. MLFD is working on their ePCR skills, and is currently still practicing with Scantrons and O1As. Mammoth Hospital is still waiting on a printer from ICEMA.

B. Base Hospital Report

Report showed an interesting spike in business for the month of April. Increase is not limited to trauma though and the Medics have been busy also.

V. OLD BUSINESS

A. Town of Mammoth AED Program

Dr. Johnson was approached by Mark Moscowitz of MLPD in regards to being the Program Director for the MLPD AED program (MLPD is CPR/AED trained and keep AEDs in their vehicles). Their program will be assisted by MLFD (Bob Rooks currently works with Ray to facilitate the County First Responder AED program, and will help Mammoth PD as well). There is nothing in place for managing the AEDs that were placed in the town buildings as of yet, and ICEMA has taken the position that the units should be removed.

B. CHP/DMV Waiver for Ambulance Drivers License

The committee was presented with another letter, drafted by Mark, to be sent as a “pre-emptive strike” to DMV Director George Valverde. The intent is to alert him to possible future requests for exemption to certain portions of the Vehicle code that define Ambulance Driver’s License requirements for volunteer fire fighters that meet certain criteria. Mark will send the and see if it generates any

response or correspondence. This exemption request has not yet been tried (by Inyo or Mono Counties.) Steve Patraw suggested contacting the California Ambulance Association if they can assist.

C. EMCC Annual Report

Still in the works, Mark may very well ask DWS for some help to expedite, as he is busy finishing projects before his retirement. Completion target prior to next EMCC for quick approval, and then BOS approval.

D. MWTC/Mono EMS MOU

Still working out the last details, should be ready for next meeting.

VI. NEW BUSINESS

A. Field Treatment Site

Dr. Johnson has put significant work into the draft of the FTS for Mono County. It is a good, well thought out document that will be open for public comment for forty five (45) days. The final version will be brought to the next EMCC.

B. Proposed 2011-2012 Fee Schedule

Generally, fees have gone up for initial certifications and re-certifications. There will also be a fee imposed for incomplete applications (failure to have proper/enough CEs, required classes, etc.). All fee changes will be approved by the ICEMA Governing Board.

ICEMA is developing a “mass gathering” policy to address EMS coverage needs for large gatherings. Dr. Johnson asked about this in regards to special event coverage for future Town and County events. This could help provide criteria for additional ambulance coverage/staffing and a possible means of offsetting costs through an EMS event fee structure.

C. Continuation of Trauma Care Protocol

This is primarily designed for the urban areas, and does not apply to Inyo and Mono Counties. Rosemary asked for an exemption in writing, which could just be an addendum or annexed written exemption in the protocol. Rosemary has similar concerns with the Stroke, Burns, STEMI and other protocols that are not relevant for Mono (or Inyo) Counties. The EMCC decided to forgo a vote on these protocols until verbiage could be added to identify these exemptions.

D. Neurovascular Stroke Center Designation Criteria

This was not discussed in any detail or depth, not directly applicable to Mono County.

E. ICEMA Policy Exemptions

Previously discussed as under item "C" (Trauma Care Protocol) above.....Request that ICEMA include exemption language for Mono and Inyo where applicable.

VII. OTHER/PUBLIC COMMENT

The EMCC was informed of the fatality of a Bowers Ambulance paramedic during a transport from Los Angeles County to Arrowhead. The Medic was asleep in the back on the way home when his partner fell asleep while driving. Both sustained injury however the medic in the back was unrestrained, ejected, and did not survive. Very unfortunate situation that acts as a reminder to us all.

Mark informed the group that he and the Fire Chiefs from the Tri-Valley area are setting up a Care Flight helicopter demo sometime in the next month or two. It is possible that the ship could end up at Mammoth Airport for another brief demo before heading back north. Mark will inform/invite interested members once a date is set.

Mark also said that the ePCR ball will start to roll in Mono County with ICEMA's assistance and Curtis Smith (Mono County paramedic) taking point for coordinating with Mark Roberts (ICEMA) and Mono County IT.

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

Bob Rooks mentioned that the EMCC should engage the Mono County Board of Supervisors in discussion about a replacement for the Chief's position as Mark is soon to retire. This was thought to be a good idea and will be discussed further.

IX. NEXT MEETING DATE AND LOCATION

The next EMCC meeting is scheduled for Tuesday, July 26, 2011 at the E.R. conference room at Mammoth Hospital, 9:00 am.

X. ADJOURNMENT

The meeting adjourned at 10:55 a.m.

Mono County Emergency Medical Care Committee (EMCC)

Draft meeting minutes for the *Special Meeting* called on July 1st, 2011.

By Mark Mikulicich, Mono County EMCC Chairman

In Attendance:

Jim Arkins.....Mono County CAO
Lori Baitx..... Mammoth Hospital ED Manager
Duane “Hap” Hazard.....Mono County Supervisor
Byng Hunt.....Mono County Supervisor
Dr. Richard Johnson.....Mono County Health Officer
Mark Mikulicich.....Mono County Paramedic Chief
Brian Muir.....Mono County Finance Director
Bob Rooks (by speaker phone).....Mono County Fire Chief’s Assoc.
Rosemary Sachs.....Mammoth Hospital Paramedic Liaison Nurse

Call to Order: 09:03

Mark Mikulicich started with a brief introduction of members and explanation for the request of the Special Meeting: to have open two-way communication between Mono EMCC members and County policy makers concerning the future leadership for the paramedic program. The quick call for a Special Meeting may have caused some initial confusion, but it was merely for (EMCC) members to give some input and to get a feel for what direction the County may take with the program and the leadership.

Dr. Johnson gave a brief explanation of EMCC bylaws and responsibilities, and the important responsibilities of the Chief’s position and interaction with the Public Health Officer. He has some additional information (to bring before the Board at a later date) from Napa County, which has similar EMS concerns as Mono.

Hap commented that he was initially wondering why the EMCC was getting involved with the EMS Chief’s position, as this is a County management decision. He sees the EMCC role as being more of a “quality of care” committee, but understands the concerns and believes input from the group is good.

Dr. Johnson said that the EMCC is primarily “quality of care” oriented, but is also concerned about sustainability of services, etc.

Lori commented that the County paramedic service has delivered a high level of care and wants to see it sustained/maintained.

Bob wanted to add that it is important for the group to know that each (EMCC) member represents a segment of EMS stakeholders within the county; he for instance represents the 11 fire districts that work hand in hand with the medics, and feels that distribution of

information regarding EMS is a responsibility of the EMCC (hence this meeting to gather as much information as possible.)

Rosemary was hopeful that there would be a continuation of leadership; that the program would have one leader, and inquired if there was any decided upon direction for the position.

Hap responded that there was no in-depth discussion yet about the Chief's position (probable discussion starting July 5th). There is no current decision on an interim position or on keeping the position vacant for a while. There are many factors that need to be addressed: upcoming meet and confer with the Paramedic Association, state and county budget issues and possible better definition of the leadership role and responsibilities which are all part of the decision process. Everything is on the table and everything will be looked at.

Byng agreed with Hap, stating that nothing was close to being set in stone and appreciates the input from the group. EMS is very important, but the program is expensive and may require modification so things may take a little time.

Lori said she understands the process, she was just concerned about what will happen in the interim (what happens August 1st, when Mark is gone?)

Hap reminded the group that the Board members have had limited heads-up regarding Mark's official departure, but realizes timing is an issue and will put effort into making proper decisions.

Byng commented that the Board still can't move too fast because of the many pending (state) budget issues that could greatly affect the County.

Jim stated that there would be options for the future and was confident that things can be maintained in the interim.

Dr. Johnson said he hears that the County will work to keep things rolling in the short-term.

Byng asked if there were any current issues in need of resolve, and Lori and Dr. J said there was nothing pending; Rosemary just wanted some consistency and interim leadership as a priority.

Hap said that when he heard Mark was leaving he knew there would be a hole in the system, but he has faith that issues can be dealt with, and it got him thinking about new roles for the Chief's position which will require more discussion. Hap commented that Mark had done well with County operations and Department management, but he viewed the role of the EMS Chief to encompass more involvement with state and federal EMS legislation and politics, and more attention to changing national EMS trends, etc. Hap

believes that the person in the leadership role should be watching the EMS world, not just focus on local operations.

Dr. Johnson said Rosemary is a great resource for the local medical issues.

Bob wanted to point out the importance of having one person in charge; doubts the Captains can be effective as equal standing managers w/o one specific person in charge. Bob agrees with Hap about the Chief's position to include more political involvement and the mindset that he or she supports the health and safety of the entire county. Bob does not think the position can share a working role on the ambulance; it must stand alone as a single administrative position.

Mark explained that some of the Chief's essential tasks will be distributed among the Captains to keep operations moving; he has had talks with Jim about this and it is in the works. Mark also suggested that Kevin Douda (Medic-3 Station Captain) be appointed to take Mark's place as the EMCC representative for the County, Dr. Johnson interjected that this must be appointed by the Board of Supervisors.

(It should be noted that there was some confusion about this as some misunderstood Mark's suggestion to be a replacement for the Chief's position, but it was only a suggestion for interim County representation at the EMCC.....MM.)

Hap spoke about the history of the county EMS program and how it was traditionally closer to a private ambulance company model. Over the years, the model has switched to more of a fire department system, but does not provide the same access to grants and other funding sources usually available to FD's. This makes decisions difficult for the Board as the paramedic program (and to a certain extent, the department Chief's position) is a very popular "political mandate" w/o a funding source, which competes financially with other various county provided services. There will undoubtedly be tough decisions ahead.

Lori said she understands the difficulty of providing services with reduced budgets and the increasing costs of doing business.

Hap said that although the Medics prefer running the first-out 911 calls, more attention to interfacility patient transfers and other aspects of EMS needs to be recognized. Hap also agrees with Bob about the accountability and responsibility of having one person in charge.

Bob stated that fire departments are taking a look at how they do business, and their focus is now on EMS; the County should also put more focus on the EMS program.

Rosemary asked if it was feasible for the paramedics to go under county Public Health.

Jim said anything is possible and there are some preliminary talks with Lynda (Salcido) concerning this.

Hap commented that when the paramedics were placed under the Sheriff's Department, it was somewhat of a recipe for failure because it was not a correct alignment; the system works best when the leadership of the paramedic department reports directly to the CAO/BOS so communication flows properly for policy development and program direction.

Brian Muir added that although there is more aggressive billing and better money collection, there are monetary issues associated with program expansion, as expanded service generally equals more costs. He realizes the political pressure, but stresses that creative thinking will be necessary and difficult decisions will have to be made for sustainability into the future.

Rosemary acknowledged that the current overtime available to the paramedics is an issue and wanted to know if an expanded list of part-time personnel might be in planned.

Jim stated that everything would be scrutinized during meet and confer negotiations in September. Mark also stated that the OT and part-time personnel list was being discussed and could provide options for reduced future operating costs.

Hap reminded everyone that as MOU negotiations worked to move (the medics) away from a Fire Department type work schedule and into a forty hour work-week timeframe, decisions were made that were costly, but effected a smooth transition. As times have changed with additional financial constraints, there is the possibility of a different structure for the program and more thoughtful discussion will need to take place to sort things out.

Dr. Johnson commented that Public Health, the Fire Departments, Mammoth Hospital and Mono County EMS are all partners, and all desire to see the high level of care and quality maintained within the system. He feels that things are on the right track and appreciates the Board's willingness to accept input.

Hap said he is glad that all entities now have a better understanding of the broad scope of these decisions, and Byng was pleased to garner input from the "front line players" acknowledging that it is important and helpful for the policy makers as they address these decisions.

There was no further discussion, other than the request for the County to let the EMCC know when any tangible decisions have been made....which will be done.

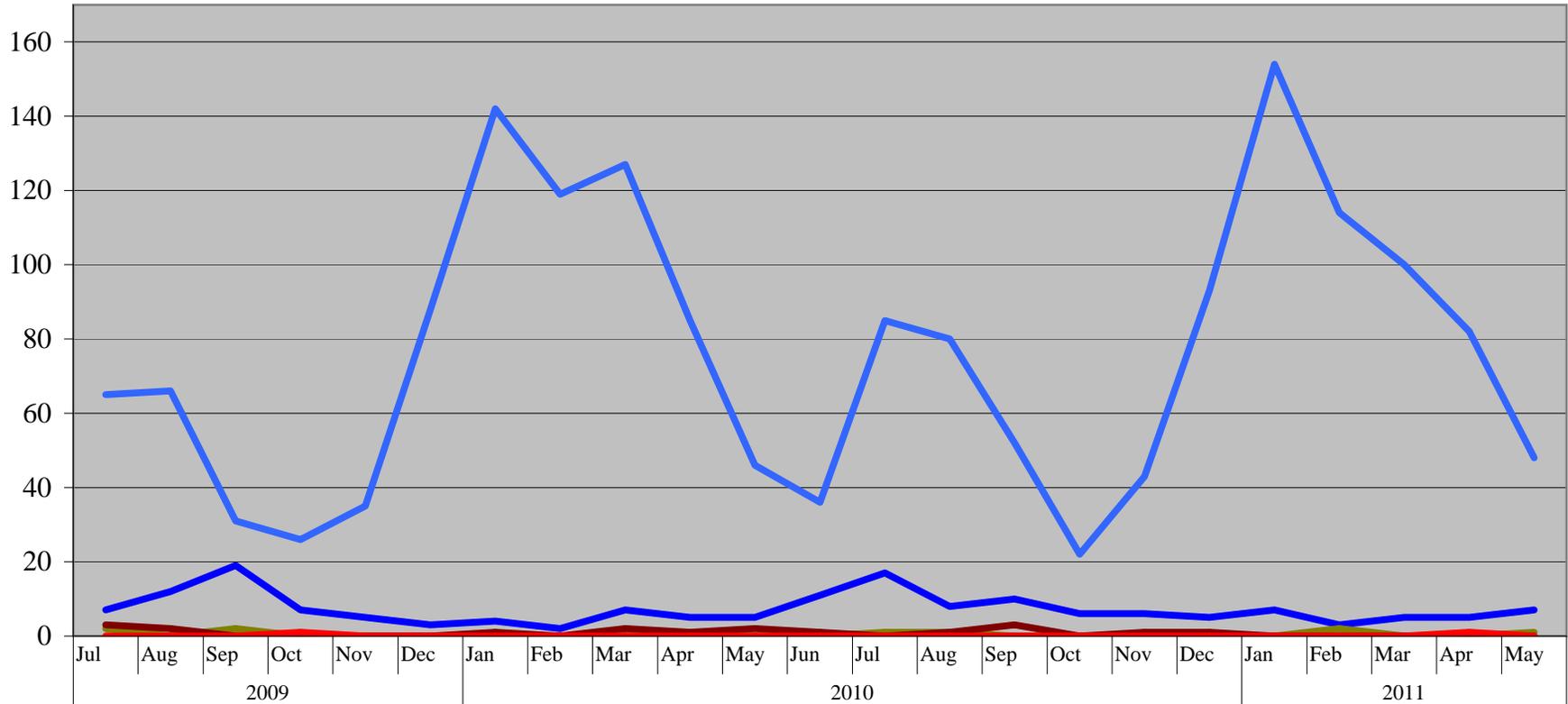
No further Special Meeting follow-up or after-action report was deemed necessary, just an update at the next scheduled EMCC.....and more info about AB 1245 for Supervisor Hazard (pending).

**The Special Meeting of the Mono County EMCC was adjourned at 10:00.
M.M.**

Mammoth Base Hospital Statistics

Patient Destination

July 2009 - May 2011



— Mammoth Hospital	65	66	31	26	35	88	142	119	127	85	46	36	85	80	52	22	43	93	154	114	100	82	48
— Carson Valley MC	7	12	19	7	5	3	4	2	7	5	5	11	17	8	10	6	6	5	7	3	5	5	7
— Carson-Tahoe Reg MC	2	0	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2	0	0	1
— Renown MC	3	2	0	0	0	0	1	0	2	1	2	1	0	1	3	0	1	1	0	0	0	0	0
— Northern Inyo	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0

Source: Base hospital self reporting.
 In 6/09 the collection tool was modified to ensure data uniformity.
 Compiled by ICEMA, ME.



**MONO COUNTY
EMERGENCY MEDICAL
CARE COMMITTEE
2010
ANNUAL REPORT**

INTRODUCTION

The Emergency Medical Care Committees (EMCC) is tasked by the Board of Supervisors, to report their observations and recommendations regarding ambulance services, prehospital emergency medical care and the training and education of prehospital service providers in the County of Mono.

The EMCC and the EMS (Emergency Medical Services) system must continually adapt to changes in prehospital care standards, review and adopt new clinical and research information.

For the local system to be successful, in addition to the compliance with mandated regulations, there must be a good operations director, a good fiscal manager, good clinicians and good visionaries and solid healthcare practices that meet local community needs.

Mono County is a member of the Inland Counties Emergency Medical Agency (ICEMA), which is headquartered in San Bernardino. ICEMA administers the emergency medical system for Mono County as well as for Inyo and San Bernardino counties in accordance with a Joint Powers Agreement.

MEMBERSHIP

The Mono County EMCC, according to its Bylaws, is comprised of the following five (5) voting members, each appointed for a period of two (2) years:

- Mono County Fire Chiefs Association representative
- Mono County Health Officer
- Mono County Paramedic Rescue Chief
- Mammoth Hospital Paramedic Liaison Nurse
- Mammoth Hospital Emergency Department Manager

PURPOSE

The Committee shall:

1. Function in an advisory manner to the local EMS Agency known as the Inland Counties Emergency Medical Agency (ICEMA), and report directly to the Mono County Board of Supervisors.
2. Participate in the planning process for the establishment of goals, objectives, policies and procedures for the local EMS agency.
3. Assist in the establishment and offer advice on policies and procedures governing prehospital care in Mono County.
4. Encourage and educate the public to understand the nature of prehospital emergency medical care and encourage support throughout the County for development and implementation of effective EMS plans.

5. Review and periodically evaluate the County's EMS program needs, services, facilities and special programs.
6. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process leading to the formation and adoption of the County EMS programs.

2010 MEETINGS

Meetings were held on January 26th, March 23nd, May 25th, July 20th, and November 2nd. Mark Mikulicich served as the Chair and Recorder.

2010 EMCC MEMBERSHIP

NAME	AFFILIATION
Mark Mikulicich	Mono County Paramedic Rescue Chief
Dr. Richard Johnson	Mono County Health Officer
Bob Rooks	Mono County Fire Chief's Association
Lori Baitx	Mammoth Hospital Emergency Department Manager
Rosemary Sachs	Mammoth Hospital Paramedic Liaison Nurse

GEOGRAPHICS AND DEMOGRAPHICS

Mono County was created by an act of the Legislature on April 21, 1861 and was the first of the mining counties to be organized as such on the eastern slope of the Sierra Nevada Mountains in the state of California. The county seat is in the town of Bridgeport, located about sixty (60) miles north of the main population center of Mammoth Lakes, where about 50% of the permanent residents reside.

Located in the east-central section of California, Mono County averages 108 miles in length, reaching from the Alpine County and state of Nevada border in the north to the Inyo County border to the south. The average width of the county is thirty-eight (38) miles from the crest of the mighty Sierras to the Nevada state line on the east. Its land area is 3,030 square miles, 80% of which is federally owned. Much of this land is contained in the Inyo and Toiyabe National Forests. The summer and fall visitors enjoy many varied activities such as fishing, hunting, camping, hiking and some of the most spectacular scenery found in the Sierra Nevada Mountains. It is a land rich in the history of the early days of the state and the west. Winter visitors engage in skiing, snowmobiling and various other winter sports at two of the finest winter sports and skiing areas to be found in the entire country. These areas are located at Mammoth Mountain and June Mountain.

The land is rough, mountainous and spectacular. In a general way, Mono is a large plateau, 5,500 to 7,000 feet above sea level bordered on the west by the Sierra Nevada Mountains and on the east by the Bodie Hills and the White Mountains. The Sweetwater Mountains lie along the northeastern border and the rugged White Mountains are located on the extreme southeastern corner of the county. Lying between these high mountain boundaries are precipitous canyons, broad valleys, many crystal clear lakes of glacial formation and sage brush covered semi-desert

land. The Sierra Nevada boundary along the western edge of Mono County is dominated by towering peaks which rise to an elevation of over 13,000 feet: Red Slate Mt., Mt. Ritter, Mt. Dana and Mt. Lyell. Land drainage in the county is accomplished by the East and West Walker Rivers to the north and by the Owens River to the south, and also by innumerable Sierra streams. Mono County lies on the western edge of the Great Basin Region of the western United States.

Mono Lake, "The Dead Sea of Mono" aptly called by poets and writers alike, "Mono's Mountains of the Moon", is vividly described in the famous book "Roughing It" by Mark Twain. The lake is a fascinating and unusual body of water lying at the beginning of a chain of 21 extinct volcanic cones. The lake nestles in a basin created by massive volcanic action. Extensive thermal activity still exists in the area surrounding the lake itself. In the center of this lake lie two islands, Negit and Paoha, that were formed by ancient volcanic action. Mono Lake and the surrounding area are famous for its water fowl population and thousands of seagulls use the locality for one of the largest rookeries in the west.

Mono County is known as the eastern gateway to Yosemite National Park. Over the famed Tioga Pass leading from the Mono Lake area to the floor of the famous valley of Yosemite may be found some of the most spectacular scenery to be found in the western United States.

The western end of Highway 6 also crosses the southern portion of Mono County through the agricultural and historical areas of Benton and Chalfant Valley. This highway connects with U.S. Highway 395 at the town of Bishop, thereby affording an excellent opportunity for persons traveling to California from the east to visit Mono County by turning north on U.S. Highway 395.

VISITOR POPULATIONS

Although the permanent resident population is about 13,000, the average daily population is about 17,000, with peaks of 40,000 during holiday periods, and projected peaks at build out within 20 years of 60,000. A significant percent of the hospital and prehospital care is delivered to out-of-town visitors. A typical patient brought to the hospital in the winter is a young snowboarder with a traumatic injury, and in the summer, an older fisherman with chest pain.

The County frequently accommodates a much larger visitor population that exceeds its permanent resident population. It is strategically positioned in the center of a vast scenic area along U.S. Highway 395, between the populous areas of Southern California and the cities of South Lake Tahoe in California, and Gardnerville/Minden, Carson City and Reno/Sparks in Nevada. Mono County is attracting an increasingly large number of permanent residents who recognize its healthful and pleasant advantages.

Source: US Census, Profile of General Demographic Characteristics: 2005-09 Community Survey which is the most recent information available

- ◆ The population of the **U.S.** on July 1, 2009 was **307,006,550**
- ◆ The population of **California** on July 1, 2009 was **36,961,664**
- ◆ The population of **Mono County** on July 1, 2009 was **12,927**

More than 50% of the permanent population lives in Mammoth Lakes.

MEDICAL RESOURCES AND PREHOSPITAL PROVIDERS

There is a single eighteen (18) bed hospital serving the population. The Southern Mono Healthcare District administers Mammoth Hospital, located in Mammoth Lakes. It has a twenty-four (24) hour Emergency Room, with on-call availability of general surgery and orthopedics. There is no neurosurgical capability. There are a number of primary and specialty care clinics affiliated with the hospital, called Sierra Park Clinics, located in Mammoth Lakes. In Bridgeport, there is a four (4) day per week clinic staffed by a Physician's Assistant, who also provides the primary jail medical coverage. It should be noted that any emergency medical requests at the jail are serviced by the County paramedics. There is a clinic at the Marine Warfare Training Center for their personnel and families, with a physician, and a number of support personnel including EMTs (Emergency Medical Technicians).

Mono County's primary ambulance transportation and emergency medical prehospital provider is the Mono County Paramedic Rescue Department. The Department consists of four (4) stocked ALS (Advanced Life Support) paramedic ambulances, with two additional ambulances in reserve. The County Paramedic Rescue Department employs twenty-four (24) paramedics (including the Chief) and one (1) EMT to staff four (4) stations along the hwy. 395 corridor in Mammoth Lakes, June Lake, Bridgeport and Walker. Ambulances provide twenty-four (24) hours a day, seven (7) days a week service. Requests for emergency medical services are made through the public 9-1-1 system, although still alarms do occur (request for help made directly at the station or directly to the station phone). Advanced life support services are provided to most of the county, with response times comparable to the standards for rural communities. Front line supervision of Mono County EMS crews, scheduling and daily operations are managed by four (4) Station Captains. The County Paramedic Chief performs all administrative functions and oversees all operations.

The Highway 6 corridor in the Tri-Valley receives very limited ALS service, with the nearest paramedic unit in June Lake or Mammoth Lakes (Mono County EMS) or Bishop (Symons Ambulance), depending on availability, the weather and road closures. BLS ambulance transportation is provided locally by the volunteers of Chalfant Fire in the southern Valley and White Mt. Fire to the north. In 2008, Mono County approved a plan to assist the District Volunteers with a paid-per-call incentive for servicing emergency medical requests in the area. A short time later, Chalfant Fire Chief (and current Mono County Paramedic) Rob DeForrest proposed responding in an "as available" volunteer ALS provider capacity, and the County agreed to supply the ALS equipment. These developments have proved to be beneficial for the area (which has historically had difficulty in recruiting and retaining volunteers) however deficiencies still exist. In 2009, Mono County purchased a plot of land centralized within the Tri-Valley. The intention was to have a lot that could be developed into a public safety facility; potentially housing fire apparatus, an ambulance and an EMS crew quarters. This project is a joint venture between the County and White Mt. Fire District. With the land secured by the County, the District is attempting to pursue outside funding sources and/or grant money for the construction of a garage bay large enough to house a fire vehicle (truck, engine or water tender) and an ambulance. The facility can be developed in stages, as funding becomes available and demand for service increases. In an effort to define development requirements and potential costs, the County has acquired preliminary plot plans that include several options for the project. This should help maximize the potential for grant awards.

Symons Emergency Specialties, a for-profit private ambulance company that provides the paramedic services for Bishop and northern Inyo County, also services the Highway 6 corridor in the southeastern part of Mono County on an “as available” basis. There is no MOU (Memorandum of Understanding) with Symons; they respond when requested and available.

OTHER RESPONDERS AND CAPABILITIES

Volunteer First Responder/EMT BLS services are available through the eleven (11) Fire Districts within the County, and a paid Federal Fire Department that services the Marine Corps Mountain Warfare Training Center (MWTC Fire Department.) These entities provide first response and back-up manpower to the County’s EMS system. There are approximately sixty (60+) EMTs working within these Special Districts county-wide. (There are approximately fifty (50) other EMTs including Hospital employees, Ski Patrol members and private citizens throughout the County.)

Other than the County ALS ambulance system, and the volunteer BLS ambulances of the Tri-Valley, the only other ambulance units readily available for back-up are the BLS ambulance of MWTC Fire (which is available under mutual aid, and may have ALS capabilities in the future) and the BLS ambulance operated by Mammoth Lakes Fire.

In the Mammoth area, where the County provides primary ALS coverage, secondary BLS ambulance transportation is available from Mammoth Lakes Fire Department as memorialized under the County’s EOA. Mammoth Hospital does have a BLS ambulance in reserve, serviceable for special events and mutual aid requests per the County. Mammoth Hospital also runs a courtesy van from Mammoth Mountain Ski Area for mildly injured patients that have refused ambulance transportation. This vehicle does not provide emergency medical services beyond basic first aid and is not considered part of the prehospital emergency medical system.

The Special Districts receive funding from the community tax base, with additional monies from the County General Fund in the form of the First Responders Fund. This Fund (\$125,000 annually) is to be utilized by the Fire Districts to assist with the costs of providing volunteer First Responder emergency medical services within their area, or in mutual aid.

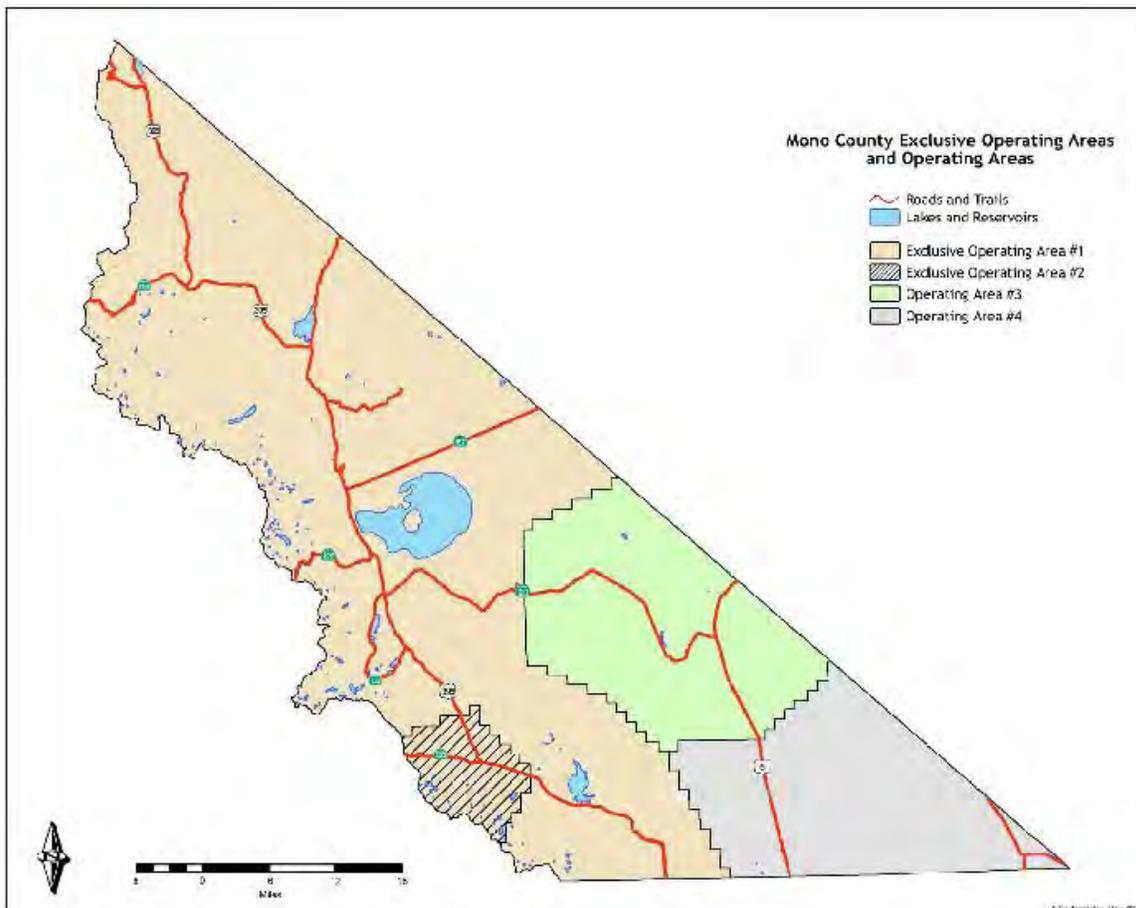
In the past, it was the objective of the Paramedic Rescue Department to have all EMS personnel cross-trained as firefighters to maximize available manpower to assist the local Special Districts with fire prevention and suppression and to assist with the development of the County's Fire Protection Plan. Although the Firefighter 1 certification is no longer a current objective, our members continue to train in Low Angle Rope Rescue, Cold Water/Ice Rescue, SCBA use for hazardous environments, Haz-Mat First Responder Operations, Vehicle Extrication and other duties and tasks designed to assist the volunteer fire departments, as the Paramedic Rescue Department and the Fire Departments work hand in hand to provide emergency medical services to the citizens and visitors.

EXCLUSIVE OPERATING AREA CONTRACT FOR AMBULANCE SERVICES

An EOA (Exclusive Operating Area) Plan was approved in 2004. This document defines and details the County's authority as the exclusive provider of Advanced Life Support ambulance transportation in certain areas of the County, and acknowledges the role of Mammoth Fire

Department as a secondary BLS ambulance provider within the Mammoth Lakes area. The EOA Plan is supported by the Mono County EMCC as a necessary function to sustain the feasibility of County provided emergency medical services.

The following illustration represents the exclusive operating areas within Mono County.



SEARCH AND RESCUE (SAR)

The Mono County Sheriff's Department oversees the County's Search and Rescue (SAR) operations; a volunteer organization of talented, trained individuals. SAR responds into the backcountry and other remote locations to provide tracking, technical rescue, medical treatment, communications and/or evacuation as needed. The Mono County SAR team is a valued key component to the County's field rescue operations. In some instances, Mono County EMS paramedics and local Fire District personnel respond with SAR for advanced treatment and additional manpower. SAR operations sometimes involve helicopter services in which case resources (airships) are provided by the USFS, CHP or the US Armed Forces as the case may be. Care Flight, out of Minden and Reno Nevada, is also utilized on rare occasions.

EMS AIRCRAFT SERVICES

Most long distance transports are done by fixed wing aircraft, due to the altitude, weather conditions and long distances. Fixed wing services that are available to the area include Sierra

LifeFlight, American MedFlight and Golden State Air Ambulance. In the case of MCI's (Multi-Casualty Incident) located at some distance from the only hospital, the IC (Incident Commander) will sometimes call in helicopter resources for direct transport to facilities outside of the county or state. Helicopters are also utilized, on occasion, for evacuation of patients from the backcountry and other remote locations as dictated by the weather and the patient's condition (see info about SAR). The main "front country" helicopter medical evacuation service would be Care Flight, based out of Minden and Reno, Nevada and Cal Star, based out of Tahoe.

DISASTER PLANNING

Disaster planning activities are coordinated between OES (Mono County Sheriff), the jurisdictional MHOAC (Mono County Public Health Officer and/or the County EMS Chief), and the RDMHS and RDMHC in Region 6 through ICEMA. Staff coordinates their efforts with other local, county, state and federal disaster planners and volunteers. ICEMA coordinates Mono County, the DMAT team and Region 6 response to requests for medical mutual aid during a declared disaster. State grant funds provide for the hiring of staff exclusively devoted to Region 6 activities. Disaster planning and drills are an on-going objective for the Paramedic Rescue Department, with interaction from other entities such as Mammoth Hospital, Mono County Public Health, Mono County Sheriff's Department and various Fire Districts.

MANPOWER AND TRAINING

Basic training, certification, recertification and continuing education standards have been established for all levels of EMS providers according to state and/or national standards. ICEMA directs effort at assuring availability of training programs, including competent and well-trained instructors. All continuing education and course content is approved by ICEMA. Most local continuing education opportunities are provided by Mammoth and Northern Inyo Hospitals, with some in-house education provided by the Mono County Paramedic staff.

Initial training at the EMT level is provided by two training centers: Cerro Coso College and High Sierra Prehospital Education; recognized by ICEMA and the State Emergency Medical Authority. In an effort to bolster EMT and First Responder education, Mono County made available an additional \$8,000 to the volunteer Fire Districts (in addition to the First Responder Fund) to pursue this objective.

Cerro Coso College does not offer training for paramedics, and does not have any outreach programs for EMTs in local volunteer fire departments.

High Sierra Prehospital Education (owned and operated by Ray McGrale) provides private instruction in CPR/First aid, AED use and EMT as well as continuing education units (CEUs) for providers.

Rosemary Sachs (Paramedic Liaison Nurse, Mammoth Hospital) provides base station field care audits on a regular basis, which are available to all County EMS employees. Other educational classes for CEU's (continuing education units) are offered thru Mammoth and Northern Inyo Hospitals.

Mammoth Fire also offers EMT level CEU's, with Fire Chief Brent Harper as the Program Director.

Emergency personnel that serve the northern portion of the County sometimes access applicable training and continuing education in Nevada.

COMMUNICATIONS

The region has very challenging communications problems due to the mountainous terrain and vast geographical distance. The Mono County Sheriff's Department takes point on the radio communication infrastructure and operations, with input from the various agencies that utilize radio communications. A coordinated ALS program, area-wide protocols, and centralized administrative program coordinate the emergency medical communications system.

Emergency Medical Services are activated via telephone/TDD access to the 911 system, located at the Sheriff's Office in Bridgeport. PSAP's (Public Safety Answering Point) request for services is communicated to providers via radio or pager.

Several years ago, significant upgrades to the communications hardware used by the volunteer fire departments, Mono County Fire/Rescue and Mammoth Hospital were obtained through grants: Homeland Security and HRSA (Health Resources and Services Administration) Hospital Bioterrorism Preparedness Program.

All dispatch personnel are employed by the Mono County Sheriff, and are located in Bridgeport. Dispatch personnel are not currently trained to provide emergency medical instructions prior to the arrival of First Responders or Paramedics.

The Public Health Officer and the Paramedic Chief both function as the MHOAC (Medical/Health Operational Area Coordinator), and will work with Emergency Medical Services and the local OES (Mono County Sheriff) in obtaining resources from outside of the jurisdiction when required, through the Region 6 RDMHC (Regional Disaster Medical/Health Coordinator - Dr. Eric Frykman) and RDMHS (Regional Disaster Medical/Health Specialist - Stuart Long).

PUBLIC INFORMATION AND EDUCATION

An ICEMA newsletter (<http://www.sbcounty.gov/icema/newsletters.aspx>) incorporates articles about pertinent information and resources that are available from other public agencies. It is published by ICEMA six (6) times per year. An ICEMA Website (www.ICEMA.net) has also been developed, which includes EMS news, continuing education class offerings, protocol updates, and various other EMS links.

MEDICAL CONTROL

Medical control assures that physicians (or MICN in consultation with the Emergency Room physician) provide direction to prehospital Advanced Life Support (ALS) personnel authorized to provide prehospital emergency medical care at the scene of an emergency and during transport or transfer to a hospital. Medical control is achieved by direct voice communication between the ALS unit and the base station. Authorized Base Stations are Mammoth Hospital and Northern

Inyo Hospital in Bishop. Region-wide written medical control protocols are continually being reviewed and updated. Protocols have been modified to allow for expanded care to be initiated prior to base station contact. The base station, ICEMA and prehospital provider agencies share the responsibility to ensure protocol compliance. The ICEMA Quality Improvement Program and provider agency QI programs provide a systematic process to monitor and evaluate the quality of emergency medical services.

In Mono County, the Public Health Officer is designated as a professional medical consultant to the county, and is directed to provide medical direction, along with the Base Station Physicians, for the paramedic services (Mono County Paramedic Rescue).

FACILITIES

The State EMS Authority has approved the ICEMA Trauma Plan, however Mono County is limited to the services provided by Mammoth Hospital; the sole facility within the County. The closest Trauma Center is renown in Reno Nevada, which is utilized when applicable and proper transportation is available (three (3) hours ground transport from South County; helicopter transport is usually needed to be effective). The County Fire/Rescue Department is working with Mammoth Hospital to better identify which patients should receive air transport to the Trauma Center.

TRANSPORTATION

The ambulance administration program ensures compliance with transportation system regulations. Ambulances are routinely inspected by ICEMA for ALS equipment and supplies in compliance with San Bernardino County ambulance ordinances and ICEMA policy. All ALS and BLS ambulances and provider agencies are inspected annually. Quality of care measures have been developed. Staff (the Paramedic Chief) investigates complaints regarding ambulance bill charges. Ambulance billing for Mono County has been contracted out to Wittman Enterprises, in Sacramento, Ca.

DATA COLLECTION

Currently, prehospital data is collected from ambulance run report forms. Information is then transferred onto a SCANTRON (bubble form) data sheet and submitted to ICEMA. The Paramedic Rescue Department is working on improving the accuracy of SCANTRON data, but information is still being missed. This is one area of noted need for improvement.

ICEMA has implemented a system wide electronic data collection system but Mono County has not fully implemented it at this time. This development and potential switch to electronic patient care reporting will be brought before the Board at a future date for approval/direction. This will entail a MOU with ICEMA for temporary use of equipment, and a future commitment by the County to acquire the needed computer modules. Mammoth Fire Department is currently training in its use.

**EMS Data Reported via SCANTRON Form
January 2010 - December 2010**

RUN SUMMARY			RUN LOCATION		
Month	Month	Runs	City	City	Runs
	January 2010	187		Mammoth Lakes	899
	February 2010	142		Bridgeport	97
	March 2010	179		June Lake	88
	April 2010	128		Mono Co. Other	57
	May 2010	104		Lee Vining	48
	June 2010	89		Walker	37
	July 2010	167		Long Valley	14
	August 2010	123		Coleville	14
	September 2010	88		Tioga Pass	13
	October 2010	45		Chalfant Valley	13
	November 2010	73		Topaz Lake	6
	December 2010	111		Mono City	3
	Total	1,436		USMC-MWTC	3
		Data Missing	144		
		Total	1,436		
Patients per Run	# of Patients	Runs	PATIENT SUMMARY		
	1	1,319	Category	Category	Patients
	2	16		Trauma	778
	3	2		Other Medical	336
	4	4		Cardiac	94
	Data Missing	95		Respiratory	49
Total	1,436	Transfer		38	
Outcome	Outcome	Runs	Behavior/OD	28	
	Xport-Ground	918	Environment	9	
	Xport-Refused	310	Domestic Violence	5	
	Xport-Air	84	Obstetric	4	
	Cancelled	51	Burn	3	
	Dry Run	31	Poisoning	3	
	Obviously Dead	9	Spinal Injury	2	
	Data Missing	33	5150	2	
	Total	1,436	Missing	85	
		Total	1,436		
Receiving Hospital	Hospital	Patients	Trauma Mechanism of Injury	Mechanism	Patients
	Mammoth Hospital	807		Sports Injury	449
	Carson Valley Med Cntr, NV	59		Other	149
	Out of Region	36		Auto/Truck-MVA	79
	Other Destination	16		Assault	22
	Washoe, NV	15		Motorcycle	20
	Carson Tahoe, NV	9		Blunt Injury	17
	LLUMC	3			
St. Mary's, NV	2				

RUN SUMMARY			RUN LOCATION			
	Loma Linda Comm	1		Fall>20'	5	
	Desert Springs, NV	1		Other Penetrating	4	
	Kaiser Permanente	1		Unknown	3	
	Data Missing	85		Gunshot	2	
	Total	1,035		Bite/Sting	2	
				Data Missing	26	
				Total	778	
Response Time (minutes)	Resp Time	Runs	Cum %	Gender	Gender	Patients
	1-3	202			Male	780
	4-6	304			Female	528
	7-9	209			Unknown	2
	10-12	205			Data Missing	126
	13-15	92			Total	1,436
	16-19	49				
	20-29	75		Age Group	Age Group	Patients
	30-39	17			<9	59
	40-49	7			9-15	136
	50-59	5			16-25	280
	60-79	6			26-35	184
	80-99	1			36-45	142
	>99	2			46-55	148
	Data Error	52			56-64	168
	Data Missing	58			65-74	134
	Data Unreadable	63			>74	94
Cancelled Call	51		Data Missing	91		
Total	1,398		Total	1,436		
Note: No response time calculated for 38 transfers.						
Scantrons by Unit	Unit	Scantrons				
	MA003	757				
	MA002	327				
	MA007	197				
	MA001	71				
	MA006	18				
	MA103	3				
	Unreadable	40				
	Data Missing	23				
	Total	1,436				

As previously stated, improvement is needed in diligence of accurate data collection/recording. It is worthy to note that not all responses and/or requests for service have a category within the current scantron system. Generally not shown in the scantron data are the paramedic's responses with local Fire Departments for situations that don't directly involve patients or other (non-medical) public assists.

Data taken directly from the 2010 station log books shows:

- **181 responses for Medic-1, Walker**
- **279 responses for Medic-7, Bridgeport**
- **374 responses for Medic-2, in June Lake**
- **888 responses for Medic-3, in Mammoth**

This equals 1,722 total responses for the Paramedic Department in 2010 which includes medical calls, public assists and fire department assists.

RECOMMENDATIONS BY THE EMCC

- Secure and stabilize future funding for EMS personnel training.
- Offer additional EMT training courses, ideally in both northern and southern areas
- Affirm commitment of system partners for future stability of EMS system.

FUTURE OBJECTIVES

INSERT LANGUAGE

SUMMARY

The EMCC encourages system wide participation and discussions. Through this interaction Mono County is able to advance its local EMS system and provide quality patient care to its citizens and the thousands of individuals who travel its highways.

Attachment A

2010 MEETING SUBJECTS

JANUARY 26, 2010

- EMS MISS Status Report
- Status – Trauma System Assessment
- Implementation of Upland Air Ambulance
- Request for Proposal – Air Ambulance EOA
- Trauma System Report (Quarterly)
- Base Hospital Statistics (Quarterly)
- ePCR Submittals (Monthly)
- Hospital Bed Delay Report (Monthly)
- Medication, Procedures, and Type of Patient Summary Reports
- ReddiNet Assessment Reports – ILI Hospital Assessment Poll
- EMCC Memberships
- PBC Trust Fund Utilization
- Protocols
 - Reference # 1050 MICN Certification
 - Reference # 6070 STEMI Receiving Center
 - Reference # 7010 BLS/ALS Drug and Equipment List
 - Reference # 7020 EMS Air Drug and Equipment List
 - Reference # 9120 Nausea and Vomiting (Zofran)
 - Reference #10100 12 lead ECG
- Election of Officers
- Annual EMCC Report

MARCH 23, 2010

- Personnel Update
 - Secretary to Virginia - Jacquie Martin
 - Trauma Nurse – Christine Yoshida-McMath
- ICEMA San Bernardino County Rate Setting Policy
- San Bernardino County Air RFP
- King Airway Survey
- EMS MISS Status Report
- ALS/BLS Reports
- Base Hospital Report
- ePCR Update
- EMT National Registry Exam Results

MAY 25, 2010

- Personnel Update
- Scantron Data
- Base Hospital Report
- Symons Ambulance
- EMTs and First Responders
- Implementation of 2010 EMT Regulations
- ICEMA Fee Schedule 2010/2011

- Nasal Administration of Medications
- Protocols
 - Reference #1050 MICN Certification Requirements
 - Reference #1080 Flight Nurse Authorization
 - Reference #6050 Pulse Oximetry Service Provider Requirements
 - Reference #6080 Paramedic Blood Draw for Chemical Test at the Request of a Peace Officer
 - Reference #8010 Interfacility Transfer Guidelines
 - Reference #9020 Physician on Scene
 - Reference #9040 Reporting Incidents of Suspected Abuse
 - Reference #9050 Organ Donor Information

JULY 20, 2010

- Medication Shortage Update
- Implementation of 2010 EMT Regulations
- Scantron Data
- Base Hospital Report
- ePCR Update
- EMTs and First Responders Update
- EMT Incident Investigation, Determination of Action,
- Notification and Administration Hearing Process – Reference #1070

NOVEMBER 2, 2010

- Medication Shortages
- STEMI
- Stroke Center Update
- MCI Reviews
- Scantron Data
- Base Hospital Report
- EMTs and First Responders Update
- Vote on letter drafted by Mono EMCC to the DMV Supervisor in regards to an exemption for dual EMT ambulance staffing in rural territory, currently covered by volunteer based BLS.

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

Protocols Comments Compiled

PROTOCOL #	AGENCY	COMMENT	RESPONSE
1040	Ontario Fire Department	We recently ran into some issues with an individual who had a “current” ACLS card, which he obtained from an online source, which we later found out did not meet the ICEMA requirements for re-certification. I understand that this was due to him not taking a manipulative portion. Ultimately however, he had a current ACLS card, which wasn’t valid. With many of the hospitals, and likely pre-hospital providers, moving towards online training you may want to consider clarifying that particular issue in the protocol.	We can clarify the protocol to read. “CPR or ACLS cards that are obtained on line must have hands on skills evaluation with an approved American Heart or equivalent instructor.”
1040 EMT-P	San Manuel Fire Department	EMT-P RE-VERIFYCATION Letter F, remove the last part “three (3) hours in each year of accreditation. The PEC agreed that field care audits can be done at any point in the 2 year accreditation cycle.	Agree with change as discussed in PEC.
3010	Ontario Fire Department	We disagree with the requirement to pay ICEMA a Training Program Approval Fee to teach the annual review class. Not only are local agencies already paying us our salary to attend the “train-the-trainer” courses, but now it appears you’re going to charge them to teach your course. By having instructors qualified to teach your annual review throughout the county it would seem it takes the burden off of you to have to provide regular training for it. The fee is inappropriate.	No change. Historically we have waived the fee however have left it on the fee schedule.
3010 EMT-P	San Manuel Fire Department	Under PROCEDURE #3, Change the wording for clarity, <u>Failure to take two different ARC's during your two year accreditation period will result in the EMT-P or MICN.....</u>	Agree will make the change.

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
5030	Ontario Fire Department	<p>The intent to implement policy changes without specific review from the public or specific committees is unacceptable. The language “but are not limited to” appears to open the door for changes which may be far more meaningful than simply changing typographical or formatting errors. “Time critical protocols or policies,” is also subjective. The language should be removed.</p> <p>Additionally, language needs to be introduced to structure protocol release on a bi-annually or semi-annual basis. Sporadic implementation, or multiple policy changes throughout the year, leads to confusion among the providers, creates difficulty in scheduling training, and will ultimately lead to policy errors and QI issues.</p>	<p>No change These will be primarily clerical changes any significant changes will continue through the normal channels.</p>
5030	Redlands Community	#2 Policy changes may occur without specific review from the public or specific committees. Changes include (the list). Eliminate the sentence “but not limited to”.	No change
5030	Upland FD	p.1: change “policy changes may occur without specific review...” to “policy changes may not occur without specific review...” OR “changes include, but are limited to:...” The time critical protocols or policies (the last bullet point) needs to be removed. This situation would fall under “Emergency Protocols/Policies.”	No change
Controlled sub. 7020	Upland FD	p.2: change “All wastage of unused portions of controlled substances ...” to “All wasted portions of controlled substances...”	Agree will change
8030 EMT-P	San Manuel Fire Department	<p>Under TRANSPORT</p> <p>#4 Remove the second part of the sentence. By the nature of our trauma system it is highly unlikely that there will be more than 20 minute difference between our Pediatric and Burn centers.</p>	#4 Change to: Pediatric burn patients identified as a CTP should always be transported to the closest trauma center with or without Burn capabilities. When there is less than

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		<p>#5 Delete the reference to EMS aircraft. It is redundant to policy 14054.</p> <p>#6, Add the word unmanageable. Change to: Burn patients with (unmanageable) respiratory compromise.....</p>	<p>20 minutes difference in transport time, a pediatric trauma center is the preferred destination.</p> <p>No change to #5</p> <p>No change to #6</p>
10060 EMT-P	San Manuel Fire Department	<p>FIELD ASSESSMENT INDICATORS</p> <p>#7 awkward sentence, change to: In blunt chest trauma consider bilateral tension pneumothorax.....</p>	Agree will change
10110 EMT-P	San Manuel Fire Department	<p>Under PROCEDURES IN SYMPTOMATIC BRADYCARDIA,</p> <p>#6 at the end of the sentence add: with signs of adequate tissue perfusion. This makes the statement consistent with #7.</p>	Agree will change
11040	Mammoth Hospital	<p>Heart rate less than 50</p> <p>Base contact after Atropine unsuccessful</p> <p>Dopamine at 2-10 mcg/kg/min</p>	<p>Change Heart rate to 50.</p> <p>No other changes</p>
11050	Mammoth Hospital	<p>Adenosine for SVT only if regular and monomorphic</p> <p>Consider Procainamide for stable wide complex SVT (not suspected WPW – this is too complicated)</p>	No change - American Heart language.
11050 EMT-P	San Manuel Fire Department	<p>Under NARROW COMPLEX SUPRAVENTRICULAR TACHYCARDIA (spelling)</p> <p>Change 4th bullet from enefective to ineffective.</p>	Agree will change
11060	Mammoth Hospital	<p>Please add exception for Inyo/Mono Counties:</p> <p>In Inyo/Mono Counties the assigned base station should be contacted for STEMI consultation.</p>	Agree will change
11060	Upland FD	<p>p.2: #5. Avoid abbreviation of MS, replace with morphine sulfate</p>	Agree will change

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
11070	Mammoth Hospital	ALS interventions # 5—can there be consistency with the wording for ETCO2 capabilities? For example, needle cric protocol states for agencies with waveform capnography document the shape of the wave and the capnography number in mmHG. Mono County also prints out the ETCO2 strips of the waveform and number for liability reasons.	Agree will make consistent
11070	Mammoth Hospital	Initiate CPR beginning with compressions Consider establishing and advanced airway Dopamine 2-10 mcg/kg/min	No change American Heart language.
11090 EMT-P	San Manuel Fire Department	Under ALS INTERVENTIONS 7 th bullet, change respiration to respiratory, to read: For B/P >90mm/Hg with no respiratory difficulties and adequate signs of tissue perfusion:	Agree will change



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director

Reza Vaezazizi, M.D., Medical Director

DATE: June 16, 2011

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Virginia Hastings
ICEMA Executive Director

Reza Vaezazizi, MD
ICEMA Medical Director

SUBJECT: PROTOCOL PUBLIC COMMENT PERIOD

The following attached twenty-two (22) protocols have been reviewed and revised by the Protocol Education Committee and the Medical Advisory Committee (MAC) and are now available for public comment and recommendations. The public comment period has been shortened due to a recommendation by the Medical Advisory Committee (MAC) to enable presentation of recommended protocols and comments to the Emergency Medical Care Committees (EMCC) in July to prevent further delay in implementation of the protocols. Many of these protocols reflect the updated American Heart Association changes and directly impact patient care.

ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until July 15, 2011 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to SShimshy@cao.sbcounty.gov.

Protocol Reference #:

- Draft Controlled Substance Policy
- 1040 Requirements for EMT-P Accreditation
- 1060 Certification/Accreditation Review Policy
- 3010 Annual Review Class (ARC)
- 5030 Procedure for Adoption of Protocols and Policies
- 6030 AED Service Provider Policy – Public Safety
- 6040 Lay Rescuer AED Implementation Guidelines
- 8030 Burn Destination and Criteria Policy
- 8060 San Bernardino County Requests for Hospital Diversion Policy
- 8080 Bed Delay Patient Destination Policy
- 9110 Treatment of Patients with Airborne Infections and Transport Recommendations
- 10060 Needle Thoracostomy
- 10070 Needle Cricothyrotomy

- 10110 Transcutaneous Cardiac Pacing
- 10120 Synchronized Cardioversion
- 10130 Automatic External Defibrillation (AED)-BLS
- 11020 Airway Obstruction – Adult
- 11040 Bradycardias – Adult
- 11050 Tachycardias – Adult
- 11060 Suspected Acute MI
- 11070 Cardiac Arrest – Adult
- 11090 Shock (Non-Traumatic)

VH/RV/DWS/SS/mae



CONTROLLED SUBSTANCE POLICY

PURPOSE

To establish minimum requirements and accountability for ICEMA approved ALS providers to procure, stock, transport, and use controlled substances in compliance with the Federal Controlled Substances Act.

POLICY

All ICEMA approved ALS providers shall have a formal agreement with a qualified Medical Director or a drug authorizing physician who agrees to purchase controlled substances using the appropriate DEA registration number and forms. This physician will retain ownership, accountability and responsibility for these controlled substances at all times. All ALS providers will develop policies compliant with Title 2, chapter 13 of the Federal Controlled Substance Act. The policies must clearly outline the procedure for procurement, receipt, distribution, waste management and associated record keeping for the controlled substances purchased under their DEA registration number.

The medical director or drug authorizing physician must be a physician licensed to practice medicine in State of California and must apply and obtain a valid DEA registration number for the ALS provider they propose to purchase controlled substances for. If a physician has agreements with multiple ALS providers, separate DEA registration numbers are required for each individual provider agency. Physicians should not use their personal DEA registration number that they use for their clinical practice.

PROCEDURE

All controlled substances will:

- Be purchased and stored in tamper evident containers.
- Be stored in a secure and accountable manner.
- Be kept under a “double lock” system at all times.
- Be counted a minimum of daily or at any change of shift or change in personnel.

Required documentation:

- ALS providers must maintain a log of all purchased controlled substances for a period of no less than 2 years.
- All controlled substance usage will be documented in patient care records.

- All wastage of unused portions of controlled substances must be witnessed and documented by at least two licensed providers (both providers must sign the log).
- In the event of breakage of a narcotic container an incident report will be completed and the damage reported to the appropriate supervisor.
- Discrepancies in the narcotic count will be reported immediately to the appropriate supervisor and a written report must be submitted.



REQUIREMENTS FOR EMT-P ACCREDITATION

PURPOSE

To define the accreditation requirements for an eligible individual to practice as an Emergency Medical Technician-Paramedic (EMT-P) within the counties of Inyo, Mono and San Bernardino.

AUTHORITY

Title 22, Division 9, Chapter 4, Section 100164 of the California Health and Safety Code.

PROCEDURE

Initial EMT-P Accreditation

1. Possess a current State Paramedic License.
2. Submit the appropriate ICEMA application with:
 - a. ICEMA Fee. The fee is not refundable or transferable.
 - b. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization in the ICEMA region.
 - c. Copy of front and back of current State [EMT-P License](#).
 - d. [Copy of current government issued photo identification.](#)
 - e. [A signed copy \(front and back\) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.](#)
 - f. [A signed copy \(front and back\) of the individual's current Advanced Cardiac Life Support Card.](#)
 - d. ~~Copy of front and back of current signed BLS/CPR and ACLS cards.~~
 - e-g. ~~Copy of course completion certificate.~~

3. Photo taken by ICEMA when application is submitted. If the application is submitted by mail, the applicant must provide a photo which is full face and passport compliant. Photocopy of the applicant's driver's license must be included for verification purposes.
- ~~3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.~~
4. A provisional card ~~may~~will be issued upon receipt of items #1 through #3. The provisional EMT-P may function using the approved State Basic Scope of Practice while working with a partner who is fully accredited as an EMT-P within the local EMS region for thirty (30) calendar days from receipt of completed application. The ICEMA Medical Director may extend this provisional status for just cause.
5. If the accreditation requirements are not completed within thirty (30) days, the applicant must complete a new application and pay a new fee to begin another thirty (30) day period. An applicant may only apply for initial accreditation a maximum of three (3) times per calendar year.
6. ~~C~~Successfully complete an orientation (not to exceed eight (8) classroom hours) of local protocols and policies given by an ICEMA approved EMT-P orientation/skills instructor and document training in all ICEMA approved optional~~undefined~~ scope of practice areas. The ICEMA Medical Director may waive this requirement for EMT-P accreditation applicants~~graduates from who graduate from~~ an approved EMT-P training institution in the ICEMA ~~this~~ region.
7. ~~P~~Successfully pass the local accreditation written examination with a minimum score of eighty percent (80%)~~skills testing in undefined scope of practice~~.
 - a. A candidate who fails to pass the ICEMA accreditation exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a score of 85%.
 - b. A candidate who fails to pass the ICEMA accreditation~~written~~ exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in ~~relation to~~ ICEMA protocols, policies / procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a score of 85%.
 - c. If the candidate fails to pass the ICEMA accreditation exam on the third attempt, the candidate **will be ineligible for accreditation for a period of six (6) months at which time candidate must reapply and successfully complete all initial accreditation requirements.**

8. Successfully complete a supervised field evaluation to consist of no less than five (5) but no more than ten (10) ALS responses. The ICEMA Medical Director may waive this requirement for EMT-P accreditation applicants who graduate from an approved EMT-P training institution in the ICEMA region who have met **all** of the following conditions:
 - a. Course completion was within six (6) months of the date of application for accreditation.
 - ~~a.~~b. Field internship was obtained within the ICEMA region with an ICEMA approved EMT-P preceptor.
 - ~~b.~~c. Complete and sign the waiver documenting items (a) and (b). No other form will be accepted.
9. The Medical Director shall evaluate any candidate who fails to successfully complete the field evaluation and may recommend further evaluation or training as required. Failure to complete the supervised field evaluation may constitute failure of the entire process.
10. ~~ICEMA~~The local EMS agency will notify individuals applying for accreditation of the decision to accredit within ~~fifteen~~thirty (30) days of receipt of completed application.

EMT-P Reverification

1. Possess a renewed California EMT-P license and current ICEMA accreditation. If ICEMA accreditation has lapsed for more than one (1) year, the individual must comply with the initial accreditation procedure.
2. Photo taken by ICEMA when Reverification form is submitted. If the form is submitted by mail, the applicant must provide a photo which is full face and passport compliant. Photocopy of the applicant's driver's license must be included for verification purposes.
~~Photo taken at ICEMA when Reverification form is submitted. A driver's license size photo (no tinted glasses or hats) may be submitted with the Reverification form~~
3. Submit the ICEMA Continuous Accreditation Reverification form with:
 - a. ICEMA fee. The fee is not refundable or transferable

- b. Verification of employment or intent to employ as an EMT-P by an authorized ALS provider agency or by an EMS provider agency that has formally requested ALS authorization by ICEMA.
- c. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
- d. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
- e. Documentation of two (2) ICEMA approved Skills Day, one (1) during each year of accreditation, a minimum of six (6) months apart.
- f. Documentation of six (6) hours of field care audits obtained within the ICEMA region, three (3) hours during each year of accreditation.

Effective January 1, 2014, failure to meet items (e) and (f) above will result in penalties as outlined in ICEMA Protocol Reference #5090- ICEMA Fee Schedule and still complete the requirements prior to reverification.

- h. Documentation of two (2) ~~consecutive~~different ICEMA Annual Review classes (ARC), -one during each year of accreditation.
~~(NOTE: This requirement will remain in effect until December 31, 2006. After that date the Annual Curriculum Class will replace the PUC.)~~

NOTE: Individuals accredited less than six (6) months must submit a new application and a current state license.

Individuals accredited more than six (6) months but less than one (1) year must submit a new application, items a-d above and complete one half of each educational requirement.

Individuals accredited more than one (1) year must complete all requirements.

Accreditation exam does not replace or fulfill the requirement for Skills Days or Field Care Audits. These must be completed prior to reverification.

- 4. Individuals without documentation of two (2) ~~consecutive~~different ARC classes must pay testing fee and penalties as set by ICEMA and ~~successfully~~pass the ICEMA accreditation exam with a score of eighty percent (80%).

5. A candidate who fails to pass the ICEMA accreditation exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a passing score of 85%.
6. An individual who fails to pass the ICEMA accreditation exam on the second attempt will have to pay the ICEMA approved fee and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies and/ procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a passing score of 85%.
7. If the candidate fails to pass the ICEMA accreditation exam on the third attempt, the candidate **will be ineligible for accreditation for a period of six (6) months at which time candidate must reapply and successfully complete all initial accreditation requirements.**



CERTIFICATION/ACCREDITATION REVIEW POLICY

PURPOSE

To establish a process for the disciplinary review of certification and/or accreditation held by all levels of prehospital care personnel within the ICEMA region.

AUTHORITY

California Health and Safety Code 1798.200-, 1798.208

California Code of Regulations, Title 22, Division 9, Chapter 6

California Government Code Title 2, Chapter 5, Section 11507.6-11507.7, 11513, 11514

POLICY

1. Disciplinary proceedings are in accordance with Title 22, Chapter 6 of the California Code of Regulations at <http://www.emsa.ca.gov/legislation/division25.rtf>.
2. Paramedic licensure actions (e.g., immediate suspension) shall be performed according to the California Health and Safety Code 1798.202.
3. Notification to the EMS Authority is through the Form EMSA-Negative Action Report at http://www.emsa.ca.gov/emt1-p/negative_action_personnel.doc.
4. If the action is to recommend to the EMS Authority for disciplinary action of an EMT-P license:
 - a. A summary explaining the actions of the EMT-P that are a threat to the public health and safety pursuant to Section 1798.200 of the Health and Safety Code; and,
 - b. Documented evidence, relative to the recommendation, collected by the Medical Director, forwarded to the State EMS Authority.
5. Request for discovery, petitions to compel discovery, evidence and affidavits shall be followed pursuant to the Administrative Procedures Act (Government Code, Title 2, Chapter 5, Sections 11507.6, 11507.7, 11513, and 11514). <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=11001-12000&file=11500-1154>.



ANNUAL REVIEW CLASS (ARC)

PURPOSE

To define the eligibility and procedural requirements for the mandatory yearly Annual Review Class (ARC) for the Paramedic (EMT-P) applying for Continuous Accreditation and/or the Mobile Intensive Care Nurse (MICN) applying for Continuous Certification or Inactive MICN status within the ICEMA Region. The Annual Review Class is developed by a multidisciplinary task-force and the curriculum approved by the ICEMA Medical Director.

PROCEDURE

1. The authorized class is valid from January 1 through December 31 of each year. ~~This protocol will apply to those individuals with expiration dates after Jan 31, 2007.~~
2. It is the responsibility of the individual to take the class during each year of accreditation or certification.
3. Failure to take an Annual Review Class during each year of accreditation or certification will result in the EMT-P or MICN having to successfully pass the ICEMA EMT-P Accreditation/MICN Certification Written Exam with a minimum score of eighty percent (80%). Additionally, financial penalties will apply.
4. The EMT-P or MICN must register and pay the exam fee to ICEMA prior to the scheduled deadline.

CRITERIA FOR TEACHING THE ANNUAL REVIEW CLASS

1. Approved C.E. providers shall request approval from ICEMA to provide the class:
 - a. Submit a completed application to be approved as a training program.
 - b. Application must include a list of your proposed trainers with copies of their resumes attached.
 - c. Pay the ICEMA approved Training Program approval fee.
 - d. Approval is granted for a period of one (1) year.

2. ICEMA should be notified thirty (30) days in advance of the class offering in order to be able to post the class dates, times and locations on the ICEMA website and newsletter.
3. Within fifteen (15) days of class completion, the provider will send the original C.E. roster to ICEMA with the Instructor Evaluation and any other material requested. All other course materials and records will be maintained, for a period of four (4) years, by the approved training program per Protocol Reference #3020, Policy for CE Provider Requirements.
4. Continuing Education hours will be granted for the class within accordance to Protocol Reference #3020 Continuing Education Provider Requirements.



PROCEDURE FOR ADOPTION OF PROTOCOLS AND POLICIES

PURPOSE

To establish ~~minimum procedural requirements~~ procedures for the adoption, amendment or repeal of ICEMA medical control protocols ~~and~~, policies and procedures.

Constituency advice and review is an essential component of policy, procedure and protocol development.

~~The provisions of this policy shall not apply to any protocol and/or policy not required to be approved by stipulation outlined in the Joint Powers Agreement.~~

The EMS constituent review process is advisory to ICEMA for the formulation of prehospital care policies and procedures. Policy/procedure suggestions and/or draft policies are accepted from committees, system participants, individuals and/or interested parties.

POLICY

1. ICEMA will review all protocols on a bi-annual basis or as necessary to ensure time critical policy changes.
2. Automatic policy changes may occur without specific review from the public or specific committees. Automatic changes include, but are not limited to:
 - changes in wording to clarify the objective
 - changes in the listed order for clarity or better flow
 - changes to assure protocol or policy continuity
 - changes required to comply with state and local law and/or regulation to maintain public health and safety.
 - correction of typographical or formatting errors
 - ~~determination that changes are needed to a protocol or policy that were not initially foreseen in its development.~~
 - time critical protocols or policies
3. ICEMA staff shall develop an initial draft with input from appropriate external

- agencies, organizations or other established advisory committees (i.e TSAC, STEMI, Stroke) as subject matter dictates, and present proposed protocols to the Protocol Education Committee (PEC) for review.
4. The PEC will provide additional input and make recommendations to ICEMA.
 5. Following review by appropriate committees, draft protocols will be submitted to the Medical Advisory Committee (MAC).
 6. Following MAC review, protocols will be released for public comment period.
 7. ICEMA shall consider all relevant matter presented to it before accepting, amending or repealing any protocol or policy.
 8. Policies will be released for thirty (30) day public comment period. The public comment period may be shortened to 15 days if ICEMA determines the policy or protocol to be time sensitive.
 9. Upon closure of the public comment period ICEMA will prepare a final draft policies/procedures with a detailed spreadsheet for presentation at the Emergency Medical Care Committee (EMCC) meetings held in all three counties. Spreadsheet shall include all comments received and ICEMA's response to the comments.
 10. Following endorsement by the EMCCs, policies will be presented to the ICEMA Medical Director and ICEMA Executive Director for signature.
 11. Protocols and/or policies approved by the Medical Director and Executive Director shall become effective no sooner than thirty (30) days after the date of approval.

EMERGENCY PROTOCOLS/POLICIES ADOPTION OR REPEAL PROCESS

1. If ICEMA determines that an emergency protocol or policy the adoption or repeal of a protocol and/or policy is necessary for the immediate preservation of the public health and safety or general welfare, a the protocol and/or policy may be adopted, amended, deleted or repealed as an emergency action of appeal.
2. Any finding of an emergency shall will include a written statement describing the specific facts showing the need for immediate action. The statement and the protocol or policy shall be immediately forwarded to the ICEMA Medical Control Advisory Committee and appropriate EMS provider agencies. The emergency protocol and/or policy will become effective no sooner than five (5) days following dissemination to the ICEMA Medical Control Advisory Committee.

3. ~~No protocols or policyies adopted under the emergency adoption provision shall remain in effect for approximately more than one hundred and twenty (120) days to allow for appropriate committee review and public comment period, unless ICEMA complies with the other provisions of this policy.~~
4. ~~A protocol or policy adopted under this emergency provision shall not be readopted as an emergency protocol or policy except with the express prior approval of the Health Officer of San Bernardino County.~~
5. ~~Protocols and/or policies approved by the Medical Director and the Health Officers shall become effective no sooner than 30 days after the date of approval by the Medical Director.~~

PUBLIC COMMENT PERIOD NOTICE OF PROPOSED ACTION — PUBLICATION, MAILING, EFFECTIVE PERIOD

ICEMA will:

1. Open all protocols to public comment for a period of thirty (30) days except in instances where the Executive Director and ICEMA Medical Director deem it necessary to shorten the period to protect and/or improve public health and safety.
2. a. Post proposed changes on the ~~ublished in the~~ ICEMA website at www.ICEMA.net/newsletter.
3. b. E-mMailed ~~proposed changes~~ to voting members of the Emergency Medical Care Committees.
ICEMA Medical Control Advisory Committee.
4. . E-mail proposed changes ~~Mailed~~ to each EMS provider agency, ~~whom ICEMA believes to be interested in the proposed action.~~
5. d. ME-mail proposed changes ~~ailed to~~ every person whom has filed a request for notificationee thereof with ICEMA.
6. ICEMA shall mMake copies of the proposed protocols and/or policies available to the public and ~~constituentsunty agencies at a nominal cost~~ which is consistent with a policy of encouraging the widest possible notice distribution to interested persons.
5. Any oversight in notification described above

~~6.7.~~ 3. — ~~The failure to mail notice to any person as provided in this policy~~ shall not invalidate any action taken by ICEMA pursuant to this policy.

CONTENTS OF NOTICE OF PROPOSED PUBLIC COMMENT PERIOD NOTIFICATION ADOPTION, AMENDMENT OR REPEAL

1. The notice of proposed adoption, amendment, or repeal of a protocol or policy shall include:

a. A statement of the time and place of proceedings for adoption, amendment, or ~~repeal~~ of a protocol or policy.

b. ~~The name and telephone number of the agency contact person to whom inquiries concerning the proposed action may be directed.~~

c. A date by which comments submitted ~~in writing~~ must be received in writing to present statements, arguments, or contentions in writing relating to the proposed action in order for them to be considered by ICEMA before it adopts, amends, or repeals a protocol or policy.

~~a.~~ —

b.d. The provisions of this section shall not be construed in any manner ~~which results to in the~~ invalidation of a protocol or policy due to perceived because of the alleged inadequacy of the notice content if there has been substantial compliance with this requirement.

~~4.~~ —

~~2.~~ — ~~The provisions of this section shall not be construed in any manner which results in the invalidation of a protocol or policy because of the alleged inadequacy of the notice content if there has been substantial compliance with this requirement.~~

CONDITIONS ON SUBSTANTIAL CHANGES OR MODIFICATIONS

~~On the date and at the time and place designated in the notice, ICEMA shall afford any interested person or his duly authorized representative, or both, the opportunity to present statements, arguments, or contentions in writing, with opportunity to present the same orally at the ICEMA Medical Control Advisory Committee Meeting. ICEMA shall consider all relevant matter presented to it before adopting, amending or repealing any protocol or policy.~~

~~2. ICEMA shall have authority to continue or postpone the ICEMA Medical Control Advisory Committee Meeting from time to time to such time and at such place as it shall determine.~~

PETITION REQUEST FOR ADOPTION, AMENDMENT OR REPEAL OF PROTOCOL CONTENTS



AED SERVICE PROVIDER POLICY – PUBLIC SAFETY

PURPOSE

To establish a standard mechanism for designation and approval of Public Safety AED Service Providers in the ICEMA region. Public Safety Personnel is defined as Firefighter, Peace Officer and/or Lifeguard.

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9, Chapter 1.5 First Aid Standards for Public Safety Personnel.

POLICY

AED Public Safety service providers shall be approved by ICEMA prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

PUBLIC SAFETY AED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit an application for a specialty program with the ~~the~~ following information to ICEMA for review and approval:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications.
5. Identify the training program to be used.
6. Policies and procedures to ensure orientation and continued competency of all AED trained personnel.
7. Procedures for maintenance of the AED.

8. Policies and procedures to collect maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.
9. Identify the Medical Director.

RECORD KEEPING AND REPORTING REQUIREMENTS

The following data will be collected and reported to ICEMA annually by March 1 for the previous calendar year.

1. ~~The total number of patients defibrillated who were discharged from the hospital alive~~
2. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care if known.
3. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) arrest and not witnessed arrest.
4. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
5. A listing of all public safety AED authorized personnel



LAY RESCUER AED IMPLEMENTATION GUIDELINES

PURPOSE

This is a guidance document to assist businesses and organizations implement Lay Rescuer automated external defibrillator programs within the ICEMA region. Using automated external defibrillators (AED) for out-of-hospital cardiac arrests has been proven to increase survival rates. ICEMA supports the use of Lay Rescuer (non-licensed or non-certified personnel person) access AEDs within the ICEMA region, and these guidelines are intended to facilitate the proliferation of AED programs.

AUTHORITY

1. California Health and Safety Code Sections 1797.5, 1797.107, 1797.190 and 1797.196.
2. California Code of Regulations Title 22, Division 9, Chapter 1.8 Sections 100031 through 100040, as revised January 8, 2009. (See Attachment C).

REQUIREMENTS OF BUSINESS/ORGANIZATION/INDIVIDUAL

1. Become familiar and comply with California AED regulations and statutes, referenced above.
2. Complete a Notification of Defibrillator Site form (Attachment A) listing each AED unit being deployed in the ICEMA region. Submit the form to:

ICEMA
515 N. Arrowhead Ave.
San Bernardino, CA 92415-0060

3. Re-submit a Notification of Defibrillator Site form if any of the information becomes outdated (i.e., the AED is moved to a different location, a new AED is purchased, etc.).
4. Every time an AED is used, complete the Report of Defibrillator Use form (Attachment B), and submit via fax to ICEMA at (909) 388-5825, within 24 hours of use.

IMPLEMENTATION CHECKLIST

Listed below are key elements taken from the California AED regulations and statutes. Each element must be satisfied to implement a Lay Rescuer AED programs within the ICEMA region.

<input type="checkbox"/>	Notify ICEMA of the existence, location, and type of every AED within the ICEMA region. The business or organization responsible for the device must, at the time the device is acquired and placed, notify ICEMA. (Attachment A).
<input type="checkbox"/>	Expected AED users/rescuers must complete a training course in cardiopulmonary resuscitation (CPR) and in use of the AED device. The training curriculum must comply with regulations adopted by the California Emergency Medical Services Authority, the standards of the American Heart Association, or the American Red Cross. The training shall include a written and skills examination.
<input type="checkbox"/>	Any AED training course for non-licensed or non-certified personnel (Lay Rescuers) shall have a physician medical director
<input type="checkbox"/>	A California licensed physician and/or surgeon must be involved in developing an internal emergency response plan for the site of the AED. The physician/surgeon is responsible for ensuring the businesses or organization's AED program complies with State regulations and requirements for training, notification, and maintenance. The internal emergency response plan shall include, but not be limited to, the provisions for immediate notification of 911 and AED-trained on-site personnel, upon discovery of the emergency. As well as procedures to be followed in the event of an emergency that may involve the use of an AED
<input type="checkbox"/>	The business/organization/lay rescuer in possession of the AED must comply with all regulations governing the training, use, and placement of the device.
<input type="checkbox"/>	The AED must be maintained and regularly tested according to the manufacturer's operation and maintenance guidelines, the American Red Cross, and American Heart Association. Maintenance and testing must also comply with any applicable rules and regulations set forth by the US Food and Drug Administration and any other applicable authority.
<input type="checkbox"/>	The AED must be checked for readiness at least once every 30 days and after each use. Records of these periodic checks shall be maintained by the business/organization in possession of the device.
<input type="checkbox"/>	A mechanism shall exist to ensure that any person rendering emergency care or using the AED activate the emergency medical services system (911) immediately. Further, the business/ organization in possession of the AED is responsible for reporting any use of the AED to the physician medical director and to ICEMA. (Attachment B).
<input type="checkbox"/>	A mechanism shall exist that assures the continued competency of the expected AED users/ rescuers employed by the business/organization in possession of the AED. Such mechanism shall include periodic training and skills proficiency demonstrations sufficient to maintain competency.
<input type="checkbox"/>	For every AED unit acquired up to five units, no less than one employee per AED unit shall complete a training course in CPR and AED. After the first five AED units are acquired, for each additional five AED units acquired, one additional employee shall be trained beginning with the first additional AED unit acquired. The business/organization in possession of the AED shall have trained employees available to respond to a cardiac emergency during normal operating hours.

ATTACHMENT A**Notification of Defibrillator Site**

Physician Medical Director Information	
Physician's Name CA Medical License No:	
Physician's Phone No:	
I am serving as the Physician Medical Director for this defibrillation program as described in the California Code of Regulations, Section 100039. I hereby certify that the AED program described herein complies with all applicable laws and regulations, including placement, use, training, and maintenance of the device(s).	
Date:	Signature:
On-Site Contact Information	
Name of On-Site Contact:	
Employer:	
Phone Number of On-Site Contact:	
Physical Address of On-Site Contact:	
Mailing Address of On-Site Contact:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

AED Location Information	
Name of Building or Complex:	
Physical Address:	
Nearest Cross Street:	
Floor and location of device placement:	
Closest/Fastest Street Access Point:	
Equipment Information	
Make:	
Model:	
Is AED in an alarmed/locked cabinet?	
Date of placement at this location:	

ATTACHMENT B

Notification of Defibrillator Site

Name Of AED Service Provider:	
Date of Occurrence:	
Time of Occurrence:	
Place of Occurrence: (Address & specific location)	
Patient's Name:	
Patient's Age:	
Patient's Sex:	
Approximate down time prior to your arrival:	
Did anyone witness the collapse/arrest?	
Alert Time (time you were notified):	
Was CPR used prior to AED at victim?	
Time of first shock (if given):	
Total number of shocks:	
Did victim regain a pulse at scene?	
Responder Name(s):	
Name and phone number of person completing form:	

Additional Comments Information:

FAX this completed report to ICEMA within 24 hours of use of an AED.

FAX to: 909-388-5825



BURN DESTINATION AND CRITERIA POLICY

PURPOSE

To ensure the appropriate destination of patients sustaining burn injuries.

AUTHORITY

Health and Safety Code Sections 1797.220, 1797.222 & 1798
California Code of Regulations, Title 22, Division 9, Sections 100144, 100304, 100107, 100128, 100175A2

DEFINITIONS

Adult Patients: a person appearing to be \geq 15 years of age.

Pediatric Patients: a person appearing to be $<$ 15 years of age.

Burn Patients: patients meeting ICEMA's burn classifications, minor, moderate or major.

Critical Trauma Patients (CTP): patients meeting ICEMA's Critical Trauma Patient Criteria.

Trauma Hospital: a licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws and regulations.

POLICY

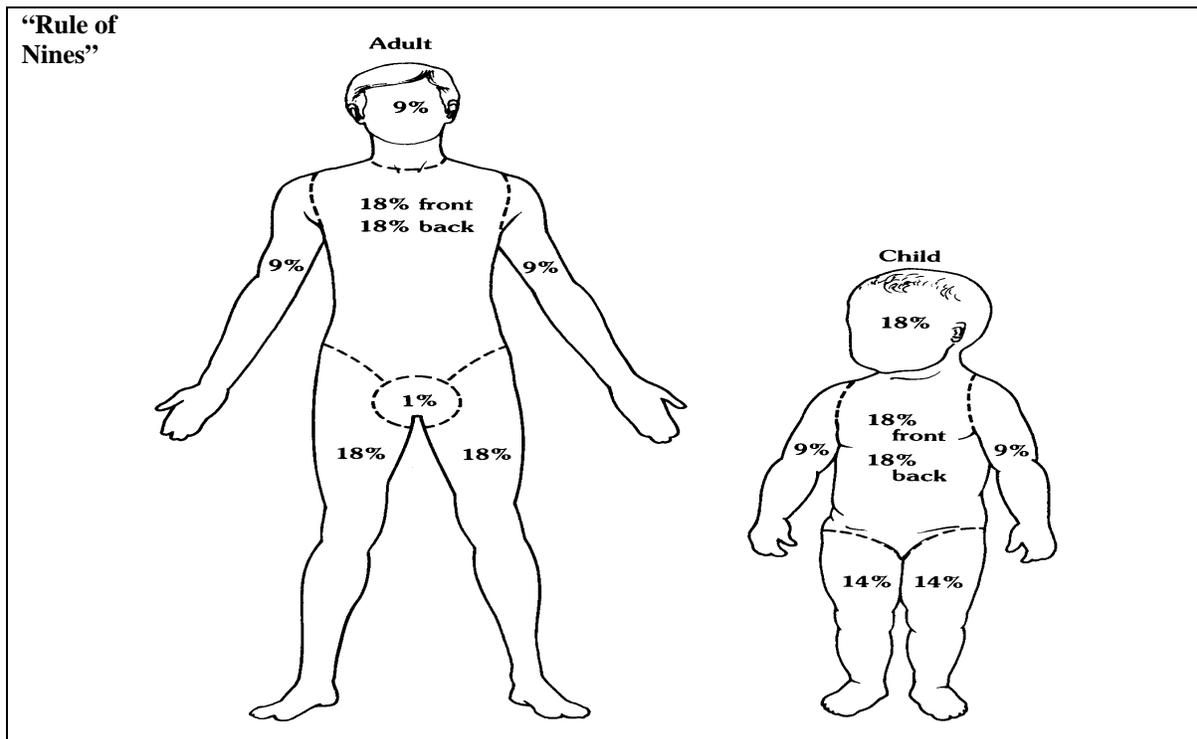
A. TRANSPORTATION

1. Burn patients meeting minor or moderate classifications will be transported to the closest **most appropriate** receiving hospital.
2. Burn patients meeting major burn classification will be transported to the closest most appropriate burn center (in San Bernardino County contact ARMC).
3. Burn patients meeting the physiologic or anatomic criteria for CTP will be transported to the most appropriate trauma hospital, Refer to Protocol #15030, Trauma Triage Criteria and Destination Policy.

4. Pediatric burn patients identified as a CTP will be transported to a pediatric trauma hospital when there is less than a twenty (20) minute difference in transport time to the pediatric trauma hospital versus the closest trauma hospital.
5. When estimated transport to the most appropriate trauma hospital (for patients identified as a CTP) is thirty (30) minutes or less, ground ambulance shall be the primary means of transport. EMS Aircraft transport shall not be used unless ground transport is expected to be greater than thirty (30) minutes and EMS Aircraft transport is expected to be significantly more expeditious than ground transport. If an EMS aircraft is dispatched, adherence to the Aircraft Destination Policy #14054 (in San Bernardino County) is mandatory.
6. Burn patients with respiratory compromise, or potential for such, will be transported to the closest ~~most appropriate~~ receiving hospital for airway stabilization.
7. Hospital trauma diversion status: Refer to Protocol #8060 San Bernardino County Hospital Diversion Policy.
8. Paramedics may contact the base hospitalstation or trauma base hospitalstation for destination consultation on any patient that does not meet any of the above criteria, but who, in the paramedic's opinion, would be more appropriately serviced by direct transport to a burn center.

B. BURN CLASSIFICATIONS

ADULT BURN CLASSIFICATION CHART	PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
<p><u>MINOR</u> – ADULT</p> <ul style="list-style-type: none"> • < 10% TBSA • < 2% Full Thickness 	<p><u>MINOR</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • < 5% TBSA • < 2% Full Thickness 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>
<p><u>MODERATE</u> – ADULT</p> <ul style="list-style-type: none"> • 10 - 20% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p><u>MODERATE</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • 5 – 10% TBSA • 2 – 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>
<p><u>MAJOR</u> – ADULT</p> <ul style="list-style-type: none"> • >20% TBSA burn in adults • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury <ul style="list-style-type: none"> • Any significant burn to face, eyes, ears, genitalia, or joints 	<p><u>MAJOR</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury <ul style="list-style-type: none"> • Any significant burn to face, eyes, ears, genitalia, or joints 	<p>CLOSEST MOST APPROPRIATE BURN CENTER</p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>



C. EXCEPTIONS

The burn patient who presents with the following:

<p>Airway Stabilization:</p> <p><u>Transport to the closest—most appropriate receiving hospital for airway stabilization when the patient:</u></p>	<ul style="list-style-type: none"> • has respiratory compromise, or potential for compromise
<p>Transport to the closest most appropriate receiving hospital when the patient:</p>	<ul style="list-style-type: none"> • has deteriorating vital signs • is pulseless and apneic
<p>EMS Aircraft Indications:</p> <p><u>An EMS aircraft may be dispatched for the following events:</u></p>	<ul style="list-style-type: none"> • MCI • Prolonged extrication time (> twenty (20) minutes) • Do Not Delay Patient Transport waiting for an enroute EMS aircraft
<p>EMS Aircraft Transport Contraindications:</p> <p><u>The following are contraindications for EMS aircraft patient transportation:</u></p>	<ul style="list-style-type: none"> • Patients contaminated with Hazardous Material who cannot be decontaminated and who pose a risk to the safe operations of the EMS aircraft and crew • Violent patients with psychiatric behavioral problems and uncooperative patients under the influence of alcohol and/or mind altering substances who may interfere with the safe operations of an EMS aircraft during flight • Stable patients

	<ul style="list-style-type: none"> • Ground transport is < 30 minutes • Traumatic cardiac arrest • Other safety conditions as determined by pilot and/or crew
Remote Locations:	<ul style="list-style-type: none"> • Remote locations may be exempted from specific criteria upon written permission from the EMS Medical Director

D. CONSIDERATIONS

1. Scene time should be limited to ten (10) minutes under normal circumstances.
2. Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be **considered** for transport to the closest most appropriate Burn Center. Trauma base hospitalstation contact shall be made.

E. RADIO CONTACT

1. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.
2. For patients meeting Trauma Triage Criteria (Physiologic, Anatomic, Mechanism of Injury, and/or Age and Co-Morbid Factors), a trauma base hospitalstation shall be contacted in the event of patient refusal of assessment, care, and/or transportation.
4. In Inyo and Mono Counties, the assigned base hospitalstation should be contacted for CTP consultation.



SAN BERNARDINO COUNTY REQUESTS FOR HOSPITAL DIVERSION POLICY

PURPOSE

To define policy and procedures for hospitals to request temporary diversion of Advanced Life Support (ALS) Ambulances.

AUTHORITY

Health and Safety Code, Division 2.5, Chapter 6, Section 1798(a), 1798.2, 1798.102; California Code of Regulations (CCR), Title 22, Division 9, Chapter 4, 100169.

PRINCIPLES

- A request for diversion of Advanced Life Support (ALS) ambulances should be a temporary measure.
- Final authority relating to destination of ALS ambulances rests with the base hospital physician.
- The approved EMS system diversion policy applies to the 9-1-1 emergency system and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.
- A hospital's request to divert in the approved categories shall be made by the emergency department attending physician or by the trauma surgeon for trauma hospital diversion, in consultation with the hospital CEO or delegated responsible administrative representative. The consultation with the administrative officer must be documented and available for review.
- Hospitals must maintain a hospital diversion policy that conforms to the ICEMA Diversion Protocol. The policy should include plans to educate all appropriate staff on proper utilization of diversion categories, internal procedures for authorizing diversion and procedures for notification of system participants.
- ICEMA may perform unannounced site visits to hospitals on temporary diversion status to ensure compliance with the ICEMA Diversion Policy.
- ICEMA may randomly audit base hospital records to ensure diverted patients are transported to the appropriate destination.

- When possible, ICEMA staff will contact the hospital to determine the reasons for internal disaster diversion.
- ICEMA reserves the right and responsibility to advise any hospital that the diversion is not appropriate for a 9-1-1 system and may remove the hospital from diversion through the Reddinet.

POLICY

A request for diversion of ALS ambulances may be made for the following approved categories:

1. Neuro/CT Diversion:

(DOES NOT APPLY FOR TRAUMA CENTERS FOR TRAUMA DIVERSION)

The hospital's CT scanner is not functioning and, therefore, is not the ideal destination for the following types of patients:

- New onset of altered level of consciousness for traumatic or medical reasons.
- Suspected stroke

2. Trauma Hospital Diversion (*for use by designated trauma hospitals only*):

The general surgeon for the trauma service and other designated trauma team resources are fully committed and are NOT immediately available for incoming patients meeting approved trauma triage criteria.

- The request for trauma diversion should only be applicable if the general surgeon and back-up general surgeon are committed. The ability to request trauma hospital diversion cannot be used in cases of temporary unavailability of subspecialists.
- **WHEN ALL DESIGNATED TRAUMA HOSPITALS ARE ON TRAUMA DIVERSION, TRAUMA CENTERS SHALL ACCEPT ALL TRAUMA PATIENTS.**

Designated trauma hospitals may not divert patients meeting trauma triage criteria to a non-designated hospital except in instances of Internal Disaster Diversion.

3. Internal Disaster Diversion:

Requests for Internal Disaster Diversion shall apply only to physical plant breakdown threatening the emergency department or significant patient services.

Examples of internal disaster diversion include bomb threats, explosions, power outage and a nonfunctional generator, fire, earthquake damage, hazardous materials exposure, incidents involving the safety and/or security of a facility.

INTERNAL DISASTER DIVERSION SHALL NOT BE USED FOR STAFFING ISSUES

- Internal Disaster Diversion shall stop all 9-1-1 transports into the facility.
- The hospital CEO or AOD shall be notified and that notification shall be documented in the Reddinet.
- If the hospital is also a designated base hospital, the hospital should consider immediately transfer of responsibility for on-line control to another base hospital based upon prearranged written agreement and notification to the 9-1-1 provider.
- Internal disaster diversion status shall be entered immediately into the Reddinet.
- If capability exists, hospital shall notify all primary 9-1-1 dispatching agencies.
- Within 72 hours, hospital shall advise ICEMA and the State Department of Health Services in writing (e-mail is acceptable) of the reasons for internal disaster and how the problem was corrected. The written notification shall be signed by the CEO or delegated responsible individual.

EXCEPTIONS TO NEURO AND TRAUMA DIVERSION ONLY:

- Basic Life Support (BLS) ambulances shall not be diverted.
- Ambulances on hospital property shall not be diverted.
- Patients exhibiting unmanageable problems, e.g., unmanageable airway, uncontrolled hemorrhage, cardiopulmonary arrest, in the field shall be transported to the closest emergency department regardless of diversion status.



BED DELAY PATIENT DESTINATION POLICY (San Bernardino County High Desert Area Only)

PURPOSE

A responsibility of an EMS agency is to assure that emergency patients requesting emergency medical care through the 9-1-1 system receive assistance and transport as quickly as possible. This is accomplished in part by requiring response time standards for all 9-1-1 providers, public and private sectors. Bed delay is threatening timely responses to such calls in the High Desert.

ICEMA protocol currently allows 9-1-1 responders to consider patient request when such request will not take the ambulance out of the service area for an extended period of time and when the condition of the patient allows transport to other than the closest appropriate emergency department.

This policy is to ensure timely responses to 9-1-1 calls and sets forth destination policies for transport to St. Mary Medical Center, Victor Valley Community Hospital and Desert Valley Hospital when the 9-1-1 response system falls below a system status level that delays timely responses to 9-1-1 calls.

AUTHORITY

Health & Safety Code, Division 2.5, Chapter 4, Local EMS Agency, Section 1797.220 and Chapter 5, Medical Control, Section 1798.

DEFINITIONS

Bed Delay: Ambulance units are determined to be on bed delay if the patient has not been removed from the ambulance gurney within twenty-five (25) minutes of arrival at hospital as documented in the ePCR.

High Desert: Exclusive Operation Areas 12, 17, 25 and 16 (excluding area south of intersection Highway 138 and Highway 2 and Wrightwood).

Deployed Ambulance Units: The number of ambulances assigned to provide service within a specific geographic area. This may vary based on provider's deployment plan.

System Status Level: The number of **available** ambulance units in a specific geographic area.

POLICY

1. When forty percent (40%), or higher, of deployed ambulance units in a specific High Desert area (excluding Barstow) are on bed delay with system status level 4 or below, or committed to other 9-1-1 calls, as determined by the dispatch center, transport providers in the High Desert area shall follow the destination policy below:
 - a. Patients shall be transported to the hospital whose emergency department has the least number of ambulances on bed delay as determined by the agency's dispatch center.
 - b. Transporting agencies may not have patients sign "Against Medical Advice" (AMA) forms as a tool to supersede this destination policy. Patients that refuse transport to the suggested facility may sign the AMA form if they choose to self transport.
 - c. Transporting units are not required to honor patient requests when this emergency protocol is implemented.
 - d. When this emergency protocol is implemented, transporters shall note the following on the patient care record:

"EMERGENCY BED DELAY DESTINATION PROTOCOL"

2. The following exceptions apply to the destination policy noted in No. 1:
 - a. Patient **meets trauma center destination criteria** ("*Trauma Triage Criteria and Destination*" Reference #15030).
 - b. Patient meets STEMI center destination criteria ("*STEMI Receiving Center Policy*", Reference #6070).
 - c. Base station direction to other facility.
 - d. Cardiac arrest or unstable patients will be transported to the closest receiving hospital regardless of bed delay.
3. When advised by dispatchers that No. 1 above is not applicable, patient requests may be honored in accordance with "*Patient Refusal of Care or Other Patient Request*", Reference #9100.

4. ICEMA will review all patient care records where destination is determined based on this policy. If a provider does not submit patient care records utilizing the ePCR, the provider must submit a copy of the patient care record to ICEMA within seventy-two (72) hours.



TREATMENT OF PATIENTS WITH AIRBORNE INFECTIONS AND TRANSPORT RECOMMENDATIONS

PURPOSE

To establish a policy for transportation of patients with suspected or known airborne infections within the ICEMA region.

AUTHORITY

California Code of Regulations, Title 8, §5199. Aerosol Transmissible Diseases.

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs and Symptoms (may include)

1. Fever > 100°F (37.8 C).
2. Runny nose, cough, sore throat (or any combination).
3. May or may not have gastrointestinal symptoms.

PROCEDURE

Patient Care

1. Treatment for a symptomatic individual who is a confirmed case or a suspected case of infectious disease is supportive based upon assessment findings.
2. IV fluids and appropriate medications are to be initiated per established protocols.
3. Exacerbation of underlying medical conditions in patients should be considered, thoroughly assessed and treated per established protocols.

Infection Control of Ill Persons During Treatment and Transport

1. EMS personnel should incorporate rapid assessment of potential infectious environment into their scene survey/safety and maintain an index of suspicion for infectious disease when a patient with signs/symptoms consistent with the case definition(s) is encountered.
2. Personal Protective Equipment (PPE) must be immediately accessible and employed by all EMS providers who come into close contact with ill and/or

- infectious patients as outlined in the California ATD Standard. This would include the driver in vehicles with open driving compartments particularly when the patient is receiving aerosolized treatment.
3. All required care should be provided to the patient(s) as indicated by protocol(s).
 4. Patients with suspected or confirmed case-status should be transported as warranted by assessment findings. All patients in acute respiratory distress will be transported. If transport is initiated, symptomatic patients should not be transported with non-symptomatic patients. The patient should be accompanied by a single attendant during transport to limit exposure unless patient treatment needs dictate otherwise.
 5. After thorough assessment and attention to the patient's respiratory status, the patient should be encouraged to wear a surgical mask if it can be tolerated or oxygen mask if indicated. Close monitoring of the patient's respiratory status is required at all times during treatment and transport.

Specific EMS Personal Protective Equipment Standards and Transport Recommendations

1. For EMS personnel treating and/or transporting a patient that meets the case definition of infectious respiratory disease, protection must include wearing a fit-tested N95 respirator (or higher), disposable gloves and eye protection (face shield or goggles).
2. The ambulance ventilation system should be operated in the nonrecirculating mode, and the maximum amount of outdoor air should be provided to facilitate dilution. If the vehicle has a rear exhaust fan, use this fan during transport. If the vehicle is equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle, use this unit to increase the number of Air Changes per Hour (ACH). Air should flow from the cab (front of vehicle), over the patient, and out the rear exhaust fan. If an ambulance is not used, the ventilation system for the vehicle should bring in as much outdoor air as possible, and the system should be set to nonrecirculating. If possible, physically isolate the cab from the rest of the vehicle, and place the patient in the rear seat.¹
3. Clean hands thoroughly with soap and water or an alcohol-based hand gel before and after all patient contacts.
4. All equipment and surface areas should be thoroughly decontaminated with an anti-bacterial cleaner following each patient contact.

¹ Centers for Disease Control, *MMWR* December 30, 2005 / 54(RR17);1-141



NEEDLE THORACOSTOMY

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs and symptoms of tension pneumothorax may include any or all of the following:

1. Increasing agitation.
2. Progressively worsening dyspnea/cyanosis.
3. Decreased or diminished breath sounds on the affected side.
4. Hypotension.
5. Distended neck veins.
6. Tracheal deviation away from the affected side.
7. Consider in blunt trauma to chest the possibility of bilateral tension pneumothorax if SPO2 remains low with a patent airway or with poor respiratory compliance.

PROCEDURE

1. Explain the procedure to the patient:
 - a. If conscious, place the patient in an upright position if able to tolerate.
 - b. If patient is unconscious or in axial-spinal immobilization, leave supine.
2. Use an approved pre-packaged device. If unable to obtain an approved pre-packaged device utilize the following:
 - a. For patients weighing more than 50kg - 14 or 16 gauge, 2 to 3 1/2 inch needle and cannula.
 - b. For patients weighing less than 50kg - 18g, 1 to 1 1/4 inch needle and cannula.
3. Prepare the area with antiseptic wipes -- second intercostal space, midclavicular line. An alternative needle thoracostomy site may include the fourth or fifth intercostal space, mid-axillary line at nipple level. Caution should be exercised in the later stages of pregnancy

when a higher (3rd) intercostal space should be used to avoid injury to the liver or spleen.

4. Insert needle perpendicular to the chest wall at the level of the superior border of the third rib until pleura is penetrated as indicated by one or more of the following:
 - a. A rush of air.
 - b. Ability to aspirate free air into the syringe.
5. Remove syringe and needle stylet and leave cannula in place with. ~~Add~~ flutter valve.
6. Secure needle hub in place with tape or other approved device.
7. Reassess patient lung sounds and respiratory status immediately and every five (5) minutes thereafter.
- ~~8. An alternative needle thoracostomy site may include the fourth or fifth intercostal space, mid axillary line at nipple level. Caution should be exercised in the later stages of pregnancy when a higher (3rd) intercostal space should be used to avoid injury to the liver or spleen.~~
9. Contact Base Station with patient update.



NEEDLE CRICOTHYROTOMY

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Upper airway obstruction with severe respiratory distress.
2. When unable to ventilate utilizing conventional airway maneuvers or devices.

ABSOLUTE CONTRAINDICATION

~~Patients less than two (2) years of age.~~
~~Transection of the distal trachea~~

PROCEDURE

1. Support ventilations with appropriate basic airway adjuncts. Use in-line cervical stabilization as needed. Explain procedure to a conscious patient.
2. Assemble appropriate equipment and pre-oxygenate prior to attempting procedure.
 - a. Locate the soft cricothyroid membrane between the thyroid and cricoid cartilage.
 - b. Insert appropriately sized needle and verify position. (An approved needle cricothyroid device may be utilized per manufacturer's guidelines.)
 - i. Adult 10-15 gauge needle.
 - ii. Pediatric 12-15 gauge needle.
 - c. Per manufacturer's recommendation, attach cannula adapter to BVM or use Translaryngeal Jet Ventilation (TLJV) device and ventilate with either BVM or TLJV (one (1) second on and three (3) seconds off).
 - d. Assist with exhalation by intermittently pressing downward and upward on chest wall if needed. Consider adding a 3-way stopcock or y-connector inline to facilitate exhalation.
3. Document verification of needle placement.
4. Monitor end-tidal CO₂ and/or pulse oximetry and chest expansion. [For agencies](#)

with waveform capnography document the shape of the wave and the capnography number in mmHG

5. Contact Base Station if unable to adequately ventilate patient and transport immediately to closest hospital for airway management.

~~5.6.~~

DOCUMENTATION

~~In the event the receiving physician discovers the device is improperly placed, an Incident Report must be completed by the receiving hospital and forwarded to ICEMA within 24 hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.~~



TRANSCUTANEOUS CARDIAC PACING

FIELD ASSESSMENT/TREATMENT INDICATORS

1. ~~Unstable~~**Symptomatic** Bradycardia - see Protocol Reference #11040 Bradycardias – Adult.
2. ~~Witnessed asystole—see Protocol Reference #11070 Cardiac Arrest—Adult.~~
3. Patient 8 years of age and younger - **not indicated**.

PROCEDURE IN SYMPTOMATIC BRADYCARDIA

1. Start at rate of 60 and adjust the output control starting at 0 milli amperes until capture is noted. Assess peripheral pulses and confirm correlation with paced rhythm.
2. Determine lowest threshold response by turning the output control down, until capture is lost, and then turn it back up slightly until capture is noted again. Maintain the output control at this level.
3. Assess peripheral pulses and confirm correlation with paced rhythm. Reassess patient for signs of adequate perfusion
4. Any movement of patient may increase the capture threshold response; the output may have to be adjusted to compensate for loss of capture.
5. With signs of inadequate tissue perfusion, increase rate (**not to exceed 100**) and contact Base Station.
6. Consider Midazolam 1-2mg slow IV push or 1-2mg IN if patient is awake and alert.
7. Consider Morphine Sulfate titrate in 1-2mg increments up to 10mg for patient complaint of pain with signs of adequate tissue perfusion.
8. Contact Base Station to advise of patient condition.

PROCEDURE IN ASYSTOLE

1. Start at maximum energy output on the pacing device.
2. Follow above procedures #2 - 4.
3. If pacing is ineffective, contact Base Station and consider termination of

resuscitative efforts.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, an Incident Report must be completed by the receiving hospital and forwarded to ICEMA within 24 hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.



SYNCHRONIZED CARディオVERSION

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Unstable V-Tach or Wide Complex Tachycardias (sustained).
2. Unstable Narrow Complex Tachycardias.
3. Unstable Atrial Fibrillation/Atrial Flutter.
3. Patient 8 years of age and younger - **not indicated.**

PROCEDURE

1. Monitor the patient in a lead that maximizes upright R wave and minimizes T wave, and observe location of synchronized marker on the R wave.
2. Consider Midazolam 1-2mg slow IV push or 1-2mg IN for all conscious patients.
3. Consider Morphine Sulfate titrated in 1-2mg increments up to 10mg slow IV push for patient complaint of pain with signs of adequate tissue perfusion.
4. Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines.
5. Procedure may be repeated at 200, 300 & 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.
6. If cardioversion is successful, continue to monitor the patient and refer to the appropriate corresponding protocol.
7. In Radio Communication failure or with Base Station order, repeated cardioversion attempts at 360 joules or a clinically equivalent biphasic energy level per manufacture's guidelines may be attempted.
8. If ventricular fibrillation should occur during preparation or following cardioversion, immediately:
 - a. Turn off synchronizer and check pulse.

- b. Charge unit to 200 - 360 joules, or clinically equivalent biphasic energy level per manufacture guidelines.
 - c. Defibrillate per the appropriate corresponding protocol.
9. Document all reassessments of rhythm and pulses.



AUTOMATIC EXTERNAL DEFIBRILLATION (AED) - BLS

PURPOSE

To identify guidelines for the use of the AED for all patients one (1) year of age or older in cardiac arrest. The overall goal of the AED program is to provide for rapid defibrillation and transfer of patients to an ALS provider as quickly as possible.

FIELD ASSESSMENT/TREATMENT INDICATORS

All of the following criteria must be met prior to applying the AED machine:

1. Unresponsive, ~~apneic and pulseless~~ pulseless and apneic (~~agonal respirations of less than six (6) per minute~~ "gaspings" breaths).
2. One (1) year of age or older.
3. Have an apparent body temperature greater than 86 degrees F.

If patient meets the criteria per Protocol Reference #12010, Determination of Death, or Protocol Reference #12020, Withholding Resuscitation, AED application is not indicated.

PROCEDURE

1. Initiate immediate CPR, ~~for two (2) minutes if time from arrest is over five (5) minutes.~~
2. Power on the AED.
- ~~2.3.~~ Place appropriate pads according to manufacturer's guidelines. If the AED is equipped with a pediatric attenuator, it should be utilized for children between one (1) and nine (9) years of age. CPR is not to be interrupted except briefly for rhythm assessment. (For children between one (1) and nine (9) years of age, pediatric pads are to be used according to manufacturers' guidelines, if available. If not using pediatric pads, follow all manufacturers' guidelines for use on the pediatric patient).
- ~~3.4.~~ Check-Analyze rhythm.
 - a. If shocks are required, each shock should be immediately followed by two (2) minutes of CPR.

- b. If additional shocks are not required:
 - i. If patient begins to move, maintain appropriate airway and oxygenation; obtain and monitor vital signs throughout care.
 - ii. If patient remains unresponsive, ~~apneic and pulseless~~pulseless and apneic, continue CPR for two (2) minutes and ~~reassess~~reanalyze.
- 4.5. Continue care as indicated by patient condition until ALS providers assume care or patient starts to move.
- 5.6. BLS agencies may only transfer care to a provider of equal or greater level. If a BLS transport agency is not an approved AED service provider, the AED personnel must accompany the patient with the appropriate equipment.

DOCUMENTATION AND QUALITY IMPROVEMENT

1. BLS agencies shall complete an ICEMA approved patient care report form and data collection device per Protocol Reference #2010, Requirements for Patient Care Records.
2. PS-D agencies must provide documentation on ICEMA approved form.
3. Use of the AED shall be evaluated by the provider agency through their QI Plan. All data will be used to compile their annual report to ICEMA.

SPECIAL NOTE

AED units should be programmed to the latest ~~2005-2010~~2010 AHA Guidelines for CPR and Emergency Cardiac Care standards for defibrillation for adults and pediatrics no later than ~~June 30, 2007~~December 31, 2011. Until personnel and equipment have been updated to the new guidelines, agencies should continue to perform CPR as trained and follow the AED prompts as directed.



AIRWAY OBSTRUCTION - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Universal sign of distress.
2. Alteration in respiratory effort and/or signs of obstruction.
3. Altered level of consciousness.

BLS INTERVENTION - RESPONSIVE

1. Assess for ability to speak or cough (e.g. "Are you choking?").
2. If unable to speak, administer abdominal thrusts/~~Heimlich maneuver~~ (if the rescuer is unable to encircle the victim's abdomen or the patient is in the late stages of pregnancy, utilize chest thrusts)~~or chest thrusts for pregnant or obese patients~~ until the obstruction is relieved or patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC's.
4. Administer oxygen therapy; if capable obtain O2 saturation, per Protocol Reference #10170, Pulse Oximetry.
5. If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

BLS INTERVENTION - UNRESPONSIVE

1. Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
2. ~~Open airway with, head tilt chin lift (for suspected trauma use jaw thrust). Remove object if visible. Assess for presence and/or effectiveness of respiration for no more than ten (10) seconds. Begin immediate CPR at a 30:2 ratio for two (2) minutes.~~
3. ~~If apneic, attempt two (2) ventilations with bag valve mask. If no chest rise, reposition airway and reattempt. Each time the airway is opened to ventilate, look for an object in the victim's mouth and if found, remove it.~~
4. If apneic and able to ventilate, provide one (1) breath every five (5) to six (6)

seconds.

~~5. If unable to ventilate, check for pulse then initiate CPR according to AHA 2005 guidelines and check for pulse every two (2) minutes until obstruction is relieved or able to ventilate.~~

~~6.5.~~ If available, place AED per Protocol Reference #10130.

ALS INTERVENTION – UNRESPONSIVE

1. If apneic and able to ventilate, establish advanced airway.
2. If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
3. If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy per Protocol Reference #10070.



BRADYCARDIAS - ADULT

ASYMPTOMATIC STABLE BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Heart rate less than 60 bpm.
2. Signs of adequate tissue perfusion.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider bolus of 300cc NS, may repeat.
2. ~~2.~~ Place on cardiac monitor and obtain rhythm strip for documentation with copy to _____ receiving hospital. If possible, obtain a 12-lead EKG to better define the rhythm.
- 2.3. Monitor and observe for change in patient condition.

SYMPTOMATIC UNSTABLE BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs of inadequate tissue perfusion/shock, ALOC, or ischemic chest discomfort.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.

3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

- ~~1. Consider advanced airway, as indicated.~~
- ~~2.1. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation.~~
- ~~3.2. Place on Cardiac monitor and obtain rhythm strip for documentation. If possible, obtain a 12-lead EKG to better define the rhythm. Provide copy to receiving hospital.~~
4. Administer Atropine 0.5mg IVP. May repeat every five (5) minutes up to a maximum of 3mg or 0.04mg/kg.
5. If Atropine is ineffective or Consider TCP, per Protocol Reference #10110, instead of Atropine for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block, utilize Transcutaneous Cardiac Pacing, per Protocol Reference #10110.
- ~~6. Attempt transcutaneous cardiac pacing of a bradycardic rhythm with continued symptoms of inadequate tissue perfusion.~~
- ~~7.6. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P greater than 90mmHg, and for signs of inadequate tissue perfusion/shock.~~
- ~~8.7. Contact Base Station if interventions are unsuccessful.~~



TACHYCARDIAS - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Signs and symptoms of poor perfusion.
2. Heart rate greater than 150 bpm.

BLS INTERVENTIONS

1. Recognition of heart rate greater than 150 bpm.
2. Reduce anxiety; allow patient to assume position of comfort
3. Administer oxygen as clinically indicated
4. Consider transport to closest hospital or ALS intercept

ALS INTERVENTIONS

Determine cardiac rhythm, obtain a 12-lead EKG to better define rhythm if patient condition allows, establish vascular access and proceed to appropriate intervention(s).

Narrow Complex Supraventricular Tachycardia (SVT)

- Initiate NS bolus of 300ml IV.
- Valsalva/vagal maneuvers
- Adenosine 6mg rapid IV push, followed by 20ml NS rapid infusion. If no conversion, may repeat twice at 12mg followed by 20ml NS rapid infusion.
- If adenosine is eneffective, —Cconsider Verapamil 5mg slow IV over three (3) minutes. May repeat every 15 minutes to a total dose of 20mg.
- Consider Procainamide 20mg/min IV for suspected Wolf-Parkinsons White; may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by more than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.
- Synchronized cardioversion; refer to Protocol Reference #10120.

- Contact Base Station.

V-Tach or Wide Complex Tachycardias (Intermittent or Sustained)

1. Consider Adenosine administration if the rate is regular and the QRS is monomorphic. Adenosine is contraindicated for unstable rhythms or if the rhythm is an irregular or polymorphic wide complex tachycardia.

~~1.2.~~ Procainamide 20mg/min IV; may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by more than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.

~~2.3.~~ If Procainamide administration is contraindicated or fails to convert the rhythm, consider Lidocaine 1mg/kg slow IV. May repeat at 0.5mg/kg every ten (10) minutes until maximum dose of 3mg/kg given and initiate infusion of 2mg/min.

4. Polymorphic VT should receive immediate unsynchronized cardioversion (defibrillation). Consider infusing Magnesium 2gms in 100ml of NS over five (5) minutes if prolonged QT is observed during sinus rhythm post-cardioversion.

~~3.~~ Magnesium 2gms in 100ml NS infuse over five (5) minutes for Torsades de Pointe.

~~4.~~ Consider Adenosine administration if arrhythmia is suspected to be of supraventricular origin.

5. Precordial thump for witnessed spontaneous Ventricular Tachycardia, if defibrillator is not immediately available for use.

6. Synchronized cardioversion; refer to Protocol Reference #10120.

~~7.~~ If arrhythmia suppressed, or cardioversion unsuccessful, administer Lidocaine 1mg/kg slow IV. May repeat at 0.5mg/kg every ten (10) minutes until maximum dose of 3mg/kg is given, then initiate infusion at 2mg/min.

~~—~~ Contact Base Station.

Atrial Fib/Flutter

1. Transport to appropriate facility.

~~If condition deteriorates, proceed to the following interventions:~~

~~2.~~ If condition deterioratesFor patients who are hemodynamically unstable, proceed to Synchronized cardioversion; refer to Protocol- Reference #10120.

~~If symptoms have been present for greater than forty eight (48) hours, electric or pharmacologic cardioversion should not be attempted unless the patient is unstable.~~

~~2.3. Contact Base Station.~~

- ~~a. Synchronized cardioversion; refer to Protocol Reference #10120.~~
- ~~b. For Narrow Complex rhythms only, give Verapamil 5mg slow IV over three (3) minutes. May repeat in fifteen (15) minutes at 10mg slow IV over three (3) minutes.~~
- ~~c. Procainamide 20mg/min IV. May repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by greater than 50% or maximum dose of 17mg/kg given. If arrhythmia suppressed, begin infusion of 2mg/min.~~
- ~~d. Contact Base Station.~~



SUSPECTED ACUTE MI

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Chest Pain (Typical or Atypical).
2. Syncopal episode.
3. History of previous AMI, Angina, heart disease, or other associated risk factors.
- ~~4. History of heart disease.~~
- ~~5. Angina.~~

BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI.
2. Reduce anxiety, allow patient to assume position of comfort.
3. O₂ as clinically indicated.
4. Obtain Oxygen saturation, ~~if trained.~~
5. May assist patient with self-administration of Nitroglycerin and/or Aspirin.

ALS INTERVENTIONS

- ~~1. Obtain rhythm strip for documentation.~~
- ~~2.1. Aspirin 162mg.~~
- ~~3.2. Consider early vascular access.~~
- ~~4.3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300ml NS bolus, may repeat.~~
- ~~5.4. 12 Lead Technology :~~
 - ~~a. If patient condition is critical, peri-arrest, do not delay transport to obtain ECG.~~

- b.a. Obtain 12 Lead ECG. Do not disconnect 12-lead cables until necessary for transport.
 - e.b. If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, ~~consider obtaining~~ obtain a right-~~chest~~sided 12 Lead (V4R).
 - d.c. If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with Base Station or receiving hospital in rural areas is recommended. (Nitrates ~~should be avoided~~ are contraindicated in the presence of ~~suspected~~ RVI or hypotension).
 - e.d. With documented ST segment elevation in two (2) or more contiguous leads, contact Base Station for destination decision while preparing patient for expeditious transport. Reference Protocol #6070, Cardiovascular Stemi Receiving Centers.
 - f.e. Repeat 12 Lead at regular intervals, but do not delay transport of patient. If patient is placed on a different cardiac monitor for transport, transporting provider should obtain an initial 12-lead on their cardiac monitor and leave 12-lead cables in place throughout transport.
- 6.5. Nitroglycerin 0.4mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. ~~Consider Morphine Sulfate for pain management when N~~ Nitroglycerin is contraindicated if there are (signs of inadequate tissue perfusion or if recent use of sexual enhancement medications have been utilized within the past forty-eight [48] hours). Utilize MS for pain control when Nitroglycerin is contraindicated.
- 7.6. Morphine Sulfate 2mg IV, may repeat every three (3) minutes to total 10mg. Consider concurrent administration of Nitroglycerin with Morphine Sulfate if there is no pain relief from the initial Nitroglycerin administration. Contact Base Station for further Morphine Sulfate orders.
- 8.7. Consider establishing a saline lock ~~enroute on same side as initial IV~~ as a secondary IV site.
9. ~~Complete thrombolytic checklist, if time permits.~~
8. ~~Contact Base Station for further Morphine Sulfate orders~~ Make early STEMI notification to the receiving STEMI center.
10. _____

~~11.9.~~ In Radio Communication Failure (RCF) may give up to an additional 10mg Morphine Sulfate in 2mg increments with signs of adequate tissue perfusion.



CARDIAC ARREST - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

BLS INTERVENTIONS

1. Assess patient, ~~maintain appropriate airway and~~ begin CPR according to current AHA Guidelines, and, maintain appropriate airway
 - a. Compression rate shall be 100/minute utilizing 30:2 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
 - a.b. Ventilation rate shall NOT exceed 12/min. Ventilatory volumes shall be the minimum necessary to cause sufficient to cause adequate chest rise.
 - b.c. Compression rate shall be 100/minute utilize 30:2 compression to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
2. If available, place AED and follow Protocol Reference #10130. CPR is **not** to be interrupted except briefly for rhythm assessment.

ALS INTERVENTIONS

1. Initiate CPR for two (2) minutes if no CPR was performed prior to arrival and down time is greater than five (5) minutes while applying the cardiac monitor.
2. Determine cardiac rhythm and proceed to appropriate intervention defibrillate if indicated. Begin a two minute cycle of CPR.
- 2.3. Obtain IV/IO access.
4. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100/min-per-minute without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.

5. Utilize continuous quantitative waveform capnography, if available, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC.

3. _____

4. _____

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

1. Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use 200 joules maximum available.
2. Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.
3. Administer Epinephrine 1.0mg IV/IO during each two (2) minute cycle of CPR after ~~each~~ every defibrillation unless capnography indicates possible ROSC.
4. Reassess rhythm ~~;~~ after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as above.
5. After two (2) cycles of CPR, consider ~~administering~~ Lidocaine 1.5mg/kg IV/IO. May repeat at 0.75mg/kg every five (5) minutes to maximum dose of 3.0mg/kg.
6. If patient remains in pulseless VF/VT after five cycles of CPR, consult base station.

Pulseless Electrical Activity (PEA) or Asystole

1. Assess for reversible causes and initiate treatment.
2. Continue CPR with evaluation of rhythm every two (2) minutes.
3. Administer fluid bolus of 300ml NS IV, may repeat.
4. Administer Epinephrine 1.0mg IV/IO during each two (2) minute cycle of CPR after each rhythm evaluation.
5. ~~Consider administration of Atropine 1.0mg IV/IO after second two (2) minute cycle of CPR. May repeat twice for a total of 3.0mg~~
6. ~~Consider termination of efforts if patient remains in PEA <60, asystole (confirm in two leads), or other agonal rhythm after successful intubation and initial medications without a reversible cause identified.~~

Utilize the following treatment modalities while managing the cardiac arrest patient:

1. ~~Insert NG/OG Tube to relieve gastric distension per Protocol Reference #10080, Insertion of NG/OG Tube. Obtain blood glucose, if indicated; administer Dextrose 50% 25gms IV.~~
2. ~~Obtain blood glucose. If indicated, administer Dextrose 50% 25gms IV. Insert NG/OG Tube to relieve gastric distension per Protocol Reference #10080, Insertion of NG/OG Tube.~~
3. Naloxone 2.0mg IV/IO/IM for suspected opiate overdose.

Termination of Efforts in the Prehospital Setting

1. The decision to terminate efforts in the field should take into consideration, first, the safety of personnel on scene, and then family and cultural considerations.
- ~~1.2. Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:~~
 - ~~a. No shocks were delivered~~
 - ~~b. No ROSC after a minimum of ten (10) minutes of ACLS~~
3. Base station contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the PCR for documentation purposes.

~~Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:~~

- ~~Arrest was not witnessed~~
- ~~Adequate bystander CPR was not provided~~
- ~~No shocks were delivered~~
- ~~No ROSC after a minimum of ten (10) minutes of ACLS~~

NOTE

1. If ROSC is achieved, obtain a 12-lead EKG.

2. Utilize continuous waveform capnography, if available, to identify loss of circulation.
- ~~1.3.~~ For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine infusion of 400mg in 250ml of NS may be initiated at 5-~~20~~1010 mcg/kg/min IV to maintain signs of adequate tissue perfusion.
- ~~2.~~ May initiate Lidocaine infusion of 2mg/min with documented conversion from VT/VF.
- ~~3.4.~~ Base station physician may order additional medications or interventions as indicated by patient condition.
- ~~4.~~ Base station contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the PCR for documentation purposes.



SHOCK (NON-TRAUMATIC)

PRIORITIES

1. ~~ABC's.~~
2. ~~Identify signs of shock.~~
3. ~~Determine need for fluid replacement.~~
4. ~~Consider early transport.~~

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Patient exhibits signs/symptoms of shock.
2. Determine mechanism of illness.
3. History of GI bleeding, vomiting, diarrhea.
4. Consider hypoglycemia or narcotic overdose.
5. ~~Hypothermia preventative measures.~~

~~ALS INTERVENTIONS~~PARAMEDIC SUPPORT PRIOR TO BASE STATION CONTACT

1. ~~Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O2 saturation on room air or on home O2 if possible.~~
2. ~~Oxygen therapy as clinically indicated. Obtain oxygen saturation on room air, unless detrimental to patient condition. Be prepared to support ventilations with appropriate airway adjuncts.~~
3. ~~Place on cardiac monitor.~~
4. ~~Place in trendelenburg if tolerated.~~
5. ~~Obtain vascular access.~~

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6. If hypotensive or has signs or symptoms of inadequate tissue perfusion give fluid challenges:

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- a. In the adult give 500ml IV bolus, may repeat once to sustain a B/P>90mmHg or until tissue perfusion improves.
- b. In the pediatric patient give 20ml/kg IV bolus, may repeat once for tachycardia, change in central/peripheral pulses, limb temperature transition, altered level of consciousness.

7. For B/P>90mmHg and no respiration difficulties and adequate signs of tissue perfusion:

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- a. In adults, maintain IV rate at 150ml/hour.
- b. In pediatric patients, maintain IV at TKO.

BASE STATION MAY ORDER

- *1. Establish 2nd large bore IV enroute.**
- *2. Dopamine infusion at 5-20mcg/kg/min if hypotension persists despite fluid administration.**

**May be done during radio communication failure.*

A-EMT Protocols Comments

PROTOCOL #	AGENCY	COMMENT	RESPONSE
7010 AEMT	San Manuel Fire	Under Limited ALS Standard Drug and Equipment list, Delete the reference to Narcotics in the first paragraph. Under Non-Exchange Airway/Suction Equipment, Change "Manual powered suction device" to Portable suction device. Add the following: End Title CO2 device – Pediatric and Adult (may be integrated into bag) 1 of each for transport and non-transport units.	Further Discussion
9010 AEMT	San Manuel Fire	Spelling Under patient contact, change "patent" to patient. Under "Limited ALS Interventions #3, change the line "augment BLS treatment with advanced treatments as indicated or available." TO, Integrate BLS and LALS treatments as clinically indicated.	Accept
13020 AEMT	San Manuel Fire	Limited ALS Interventions, #4 References AEMT prorocol14060. There is no protocol #14060 in the AEMT package? This could be a reference to EMT-P protocol 14060? If so add "when assisting an EMT-P".	Accept
15010 AEMT	San Manuel Fire	Page 2, Under "Isolated Head Injury" Delete the bullet "Insert nasogastric/orogastric tube". Under Traumatic Arrest Delete reference to Monitor V-Fib or V-Tach and defibrillate as per ACLS guidelines. Consider changing to "Apply AED and follow AED mfg. guidelines."	Accept
9020 AEMT	San Manuel Fire	Under PROCEDURE, change EMT-P to AEMT.	Accept
10010 AEMT	San Manuel Fire	Add the use of End Title CO2 device – Pediatric and Adult. This should be added to the Standard Drug and equipment list also. Also add the use of capnography if it is available on scene.	Accept

PROTOCOL PUBLIC COMMENT PERIOD ENDS JULY 15, 2011 5 P.M.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
10010 AEMT and 10020 AEMT	San Manuel Fire	Under PROCEDURE, Either remove the numbers and use bullet points, OR Place #5 Pre-Oxygenate in the #1 place. AEMT has no devices using airway circuits. To reflect this in #12 change, "attach the breathing circuit" to Attach the BVM and End Title C02 device to the King LT.	Further Discussion
10160 AEMT	San Manuel Fire	Remove #4, OR change to: all neonatal and pediatric patients with a KING LT airway".	Further Discussion
11100 AEMT	San Manuel Fire	Page 3 Under Respiratory distress: Remove "Place advanced airway if the patient presents facial/oral swelling or if respiratory depression develops due to inhalation injury." In inhalation burns The King LT may add to the edema in the oropharynx and its use should be discouraged. Consider changing to "Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP."	Further Discussion
13013 AEMT	San Manuel Fire	Under LIMITED ALS INTERVENTIONS #1, CHANGE "Advanced airway as clinically indicated" to, Airway interventions as clinically indicated.	Accept



Inland Counties Emergency Medical Agency

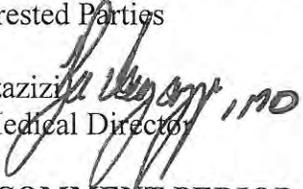
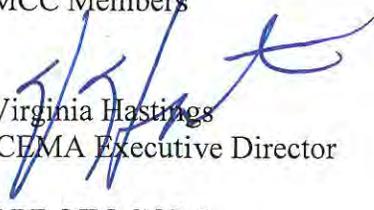
Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director

Reza Vaezazizi, M.D., Medical Director

DATE: June 16, 2011

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Reza Vaezazizi, M.D.  ICEMA Medical Director
Virginia Hastings  ICEMA Executive Director

SUBJECT: PUBLIC COMMENT PERIOD - AEMT PROTOCOLS

Over the past several years, in conjunction with San Bernardino County Sheriff's Search and Rescue team, West Valley Division, ICEMA participated in a trial study for EMTs to provide specific limited ALS (LALS) services to patients in remote wilderness areas. Through this study and Statewide input of existing EMT-II programs, the State EMS Authority implemented the Advanced EMT (AEMT) scope of practice.

Title 22 of the California Code of Regulations, Chapter 3 authorizes local EMS agencies to establish LALS programs, through program approval and written agreements. ICEMA has established the LALS program and application processes to allow providers to upgrade from BLS provider status to LALS service to enable higher levels of care to citizens, particularly in rural and wilderness areas. Interested agencies will be required to submit a specialty program application, enter into a written agreement and be approved by ICEMA. Additional training and certification of personnel will also be required for program approval.

Attached are the LALS Advanced EMT protocols available for public comment. The protocols were adapted from existing protocols to include the AEMT scope of practice and will be used exclusively by ICEMA approved LALS providers. ICEMA encourages all system participants to submit comments/recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until July 15, 2011 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to SShimshy@cao.sbcounty.gov. A recommendation was made and approved by the Medical Advisory Committee to release these protocols for a shortened comment period in order to be presented at the July 2011 Emergency Medical Care Committee (EMCC) meetings held in all three counties.

RV/VH/DWS/SS/mae

Attachments: A-EMT Limited ALS Protocols



LIMITED ALS STANDARD DRUG & EQUIPMENT LIST

Each ambulance and first responder unit will be equipped with the following functional equipment and supplies. **This list represents mandatory items with minimum quantities** excluding narcotics which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

All ALS, Limited ALS, (transport and non-transport) and BLS transport vehicles shall be inspected annually.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	L-ALS Non-Transport
Activated Charcoal 25 gm	2
Adrenaline (Epinephrine) 1:1000 1 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg	4
Aspirin, chewable – 81mg tablet	2
Dextrose 50% 25 gm preload	2
Glucagon 1 mg	1
Glucose paste	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg	4
Irrigating Saline and/or Sterile Water (1000cc)	1
Naloxone (Narcan) 2 mg preload (needle less)	2
Nitroglycerine – Spray or tabs 0.4mg metered dose	2
Normal Saline for Injection (10cc)	2
Normal Saline 500cc	2
Normal Saline 1000cc	1

AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	L-ALS Non-Transport
Adult non-rebreather mask	2
Infant Simple Mask	1
King LTS-D Adult: 4-5 feet: Size 3 (yellow) 5-6 feet: Size 4 (red) Over 6 feet: Size 5 (purple)	1 each
King Ped: 35-45 inches or 12-25 kg: Size 2 (green) 41-51 inches or 25-35 kg: Size 2.5 (orange)	1 each
Nasal cannulas – pediatric and adult	2 each
Nasopharyngeal Airways – (infant, child, and adult)	1 each

Exchanged Airway/Suction Equipment	L-ALS Non-Transport
Oropharyngeal Airways – (infant, child, and adult)	1 each
Pediatric non-rebreather O2 mask	2
Small volume nebulizer with universal cuff adaptor	2
Ventilation Bags – Infant 250ml, Pediatric 500ml (or equivalent)	1 each
Adult	1 each
Water soluble lubricating jelly	1

Non-Exchange Airway/Suction Equipment	L-ALS Non-Transport
Flashlight/penlight	1
Portable Oxygen with regulator – 10L/min for 20 minutes	1
Manual powered suction device	1
Pulse Oximetry device	1
Stethoscope	1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

IV/Needles/Syringes/Monitoring Equipment	L-ALS Non-Transport
Disposable Tourniquets	2
Glucose monitoring device with compatible strips and OSHA approved single use lancets	1
IV Catheters – sizes 14, 16, 18, 20, 22, 24	2 each
Microdrip Administration Set (60 drops/cc)	1
Macro drip Administration Set (10 drops/cc)	3
Mucosal Atomizer Device (MAD) for nasal administration of medication	2
Pressure Infusion Bag (disposable)	1
Razors	1
Safety Needles – 20 or 21gauge and 23 or 25 gauge	2 each
Saline Lock Large Bore Tubing Needle less	2
Sterile IV dressing	2
Syringes w/wo safety needles – 1cc, 3cc, 10cc catheter tip	2 each

Non-Exchange IV/Needles/Syringes/Monitoring Equipment	L-ALS Non-Transport
AED/defib pads	2
Blood pressure cuff – large adult or thigh cuff, adult, child and infant	1
Needle disposal system (OSHA Approved)	1
Thermometer - Mercury Free with covers	1



GENERAL PATIENT CARE GUIDELINES

PURPOSE

To provide guidelines for providing the minimum standard of care for all patient contacts.

AUTHORITY

Title 22, Division 9, Chapter 4, Sections 1001, 100146 and 100147 of the California Health and Safety Code.

DEFINITIONS

Patient: An individual with a complaint of pain, discomfort or physical ailment. An individual regardless of complaint, with signs and/or symptoms of pain, discomfort, physical ailment or trauma. These signs/symptoms include, but are not limited to:

1. Altered level of consciousness.
2. Sign and/or symptoms of skeletal or soft tissue injuries.
3. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
4. Evidence that the individual was subject to significant force.

Patient Contact: Determined to be achieved when any on duty BLS or ALS field provider comes into the presence of a patient as defined above.

BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
 - a. Airway, breathing and circulatory status.
 - b. Subjective assessment of the patients' physical condition and environment.
 - c. Objective assessment of the patients' physical condition and environment.
 - d. Vital signs.

- e. Prior medical history and current medications.
 - f. Any known medication allergies or adverse reactions to medications, food or environmental agents.
2. Initiate care using the following tools as clinically indicated or available:
 - a. Axial spinal immobilization.
 - b. Airway control with appropriate BLS airway adjunct.
 - c. Oxygen.
 - d. Assist the patient into a physical position that achieves the best medical benefit and maximum comfort.
 - e. Automated External Defibrillator (AED).
 - f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated.
 3. Assemble necessary equipment for ALS procedures under direction of EMT-P.
 - a. Cardiac monitoring
 - b. IV/IO
 - c. Endotracheal Intubation
 4. Under EMT-P supervision, assemble pre-load medications as directed, excluding controlled substances.

LIMITED ALS INTERVENTIONS

1. Evaluation and continuation of all BLS care initiated.
2. Augment BLS assessment with an advanced assessment including but not limited to the following:
 - a. Qualitative lung assessment.
 - b. Blood glucose monitoring

3. Augment BLS treatment with advanced treatments as indicated or available.
4. Initiate airway control as needed with the appropriate LALS adjunct.
5. Initiate vascular access as clinically indicated.



PHYSICIAN ON SCENE

PURPOSE

To establish criteria for an A-EMT during situations in which a physician is physically present at the scene of a 9-1-1 response.

AUTHORITY

Division 9, Chapter 4, Article 2, Section 100147 and Article 8, Section 100175 of the California Code of Regulations.

POLICY

Medical responsibility for patient care is the responsibility of the Base Station physician. Within the ICEMA Region, an A-EMT may only follow medical orders given by the Base Station physician or MICN.

PROCEDURE

In the event that an EMT-P arrives at the scene of a medical or a trauma emergency and a physician on scene wishes to direct the care of the patient and assume medical responsibility for the patient, the following conditions apply:

1. The physician must be informed that Base Station contact must be made, and the final decision regarding the assumption of medical responsibility for patient care will be made by the Base Station physician.
2. The physician must show proper identification and a current California physician's license.
3. The physician must agree to sign the patient care record agreeing to take full responsibility for the care and treatment of the patient(s) involved in the incident and accompanies the patient(s) in the ambulance to the medical facility most appropriate to receive the patient(s). This statement is available on the ICEMA e-PCR and on the back of the first (white) copy of the ICEMA Standard Run Report Form (01A). Prehospital EMS agencies using software not totally integrated with ICEMA software must provide a form stating the above and obtaining physician signature.
4. Care of the patient must be transferred to a physician at the receiving facility.

RESPONSIBILITIES

The A-EMT has the following responsibilities in the event that the physician on scene assumes responsibility for patient care:

1. Notify Base Station that a physician is taking charge of the patient(s).
2. Maintain control of drugs and equipment from the Limited ALS unit. Inform the physician of drugs and equipment available.
3. Offer assistance to the physician on scene. The A-EMT may only perform procedures that are within the ICEMA scope of practice.
4. Document on patient care record all necessary information and obtain physician signature.



RESPONSIBILITY FOR PATIENT MANAGEMENT POLICY

PURPOSE

To define the responsibility for patient care management in the prehospital setting. Within the ICEMA region, in the event both public and private emergency medical care personnel arrive on the scene with the same qualifications, patient care management responsibility will rest with the first to arrive.

AUTHORITY

Health & Safety Code, Division 2.5, Chapter 5, Section 1798.6 (a & c).

- a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic, A-EMT or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care.
- b) If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.
- (c) Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in determination of relevant risks.

PROCEDURE

1. An A-EMT may transfer patient management responsibility to an EMT for transportation, **without Base Station direction**, only under the following conditions:
 - a. When the patient does not meet criteria for Base Station contact and has not received Limited ALS care.
 - b. When operating under the MCI Protocol, Reference #5050.

- c. When operating under the Local Medical Emergency Protocol, Reference #9060 AEMT.
2. The Base Station should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.
3. In the event of radio communication failure, a Limited ALS unit may not transfer patient management responsibility to an EMT for transportation.



REPORTING INCIDENTS OF SUSPECTED ABUSE POLICY

PURPOSE

Prehospital personnel are required to report incidents of suspected neglect or abusive behavior towards children, dependant adults or elders. These reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report.

When two or more persons who are required to report are present at scene, and jointly have knowledge of a suspected abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

Information given to hospital personnel does not fulfill the required reporting mandated from the state. The prehospital caregivers must make their own report.

CHILD ABUSE/NEGLECT

Suspicion of Child abuse/neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline immediately or as soon as possible. Be prepared to give the following information:

1. Name of person making report.
2. Name of child.
3. Present location of child.
4. Nature and extent of the abuse/neglect.
5. Location where incident occurred, if known.
6. Other information as requested.

San Bernardino County: 1-800-827-8724 24-hour number **or** 1-909-384-9233

Inyo County: 1-760-872-1727 M-F 8am - 5pm **or** 911 after hours

Mono County: 1-800-340-5411 M-F 8am - 5pm **or** 1-760-932-7755 after hours

The phone report must be followed within 36 hours by a written report on the “**Suspected Child Abuse Report**” form. Mail this to:

San Bernardino County: CPS
412 W. Hospitality Lane
San Bernardino, CA 92408

Inyo County: CPS
162 Grove St. Suite “J”
Bishop, Ca. 93514

Mono County Department of Social Services
PO Box 576
Bridgeport, Ca. 93517

The identity of any person who files a report shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protection agency, or to the district attorney in a criminal prose.

DEPENDENT ADULT AND ELDER ABUSE/NEGLECT

Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by telephone. Be prepared to give the following information:

1. Name of person making report.
2. Name, address and age of the dependent adult or elder.
3. Nature and extent of person’s condition.
4. Other information, including information that led the reporter to suspect either abuse or neglect.

San Bernardino County: 1-877-565-2020 24-hour number

Inyo County: 1-760-872-1727 M-F 8am - 5pm **or** 911 after hours

Mono County: 1-800-340-5411M-F 8am - 5pm **or** 1-760-932-7755 after hours

The phone report must be followed by a written report within 48 hours of the telephone report on the “**Report of Suspected Dependent Adult/Elder Abuse**” form. Mail this report to:

San Bernardino County: Department of Aging/Adult Services
881 West Redlands Blvd. *Attn:* Central Intake
Redlands, CA 92373
Fax number 1-909-388-6718

Inyo County: Social Services
162 Grove St. Suite “J”
Bishop, Ca. 93514

Mono County: Department of Social Services
PO Box 576
Bridgeport, Ca. 93517

The identity of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.

San Bernardino County Department of Aging and Adult Services Long-Term Care Ombudsman Program

Ombudsmen are independent, trained and certified advocates for residents living in long-term care facilities. Certified Ombudsmen are authorized by Federal and State law to receive, investigate and resolve complaints made by or on behalf of residents living in skilled nursing or assisted living facilities for the elderly. Ombudsmen work with licensing and other regulatory agencies to support Resident Rights and achieve the best possible quality of life for all long-term care residents. Ombudsman services are confidential and free of charge.

Administrative Office

Receives All Reports of Abuse
686 E. Mill St.
San Bernardino, Ca 92415-0640
909-891-3928 Office
1-866-229-0284 Reporting
Fax 909-891-3957

The State CRISIS line number:

1-800-231-4024

This CRISIS line is available to take calls and refer complaints 24 hours a day, 7 days a week.



ORGAN DONOR INFORMATION

PURPOSE

To comply with state legislation requiring emergency medical services (EMS) field personnel to search for organ donor information on adult patients for whom death appears imminent.

AUTHORITY

California Health and Safety Code, Section 7152.5, b (3) and c, d and e.

DEFINITIONS

Reasonable Search: A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver's license or other identification card with this information. A reasonable search shall not take precedence over patient care/treatment.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at the receiving hospital.

POLICY

Existing law provides that any individual who is at least eighteen (18) years of age may make an anatomical gift and sets forth procedures for making that anatomical gift, including the presence of a pink dot on their drivers license indicating enrollment in the California Organ and Tissue Donor Registry.

1. When EMS field personnel encounter an unconscious adult patient for whom it appears death is imminent, a reasonable search of the patient's belonging should be made to determine if the individual carries information indicating status as an organ donor. This search shall not interfere with patient care or transport. Any inventory of victim's personal effects should be on the patient care record and signed by the person who receives the patient.
2. All EMS field personnel shall notify the receiving hospital if organ donor information is discovered.

3. Any organ donor document discovered should be transported to the receiving hospital with the patient unless the investigating law enforcement officer requests the document. In the event that no transport is made, any document should remain with the patient.
4. EMS field personnel should briefly note the results of the search, notification of hospital and witness name(s) on the patient care report.
5. No search is to be made by field personnel after the patient has expired.



LOCAL MEDICAL EMERGENCY POLICY

PURPOSE

To provide guidelines to prehospital care providers and personnel regarding the treatment and transportation of patients during a declared Local Medical Emergency.

POLICY

Prehospital care providers and personnel shall follow the procedures and guidelines outlined below regarding the treatment and transportation of patients during a declared Local Medical Emergency.

DEFINITION

Local Medical Emergency: For the purposes of this policy, a Local Medical Emergency shall exist when a “local emergency”, as that term is used in government Code Section 8630, has been proclaimed by the governing body of a city or the county, or by an official so designated by ordinance.

ENACTMENT OF PROTOCOL

The following procedures shall apply during a Local Medical Emergency:

1. A public safety agency of the affected jurisdiction shall notify the County Communications Center of the proclamation of a local emergency, and shall provide information specifying the geographical area that the proclamation affects.
2. The Communications Center shall notify:
 - a. The County Health Officer/Designee.
 - b. ICEMA.
 - c. The County Sheriff’s Department.
 - d. Area prehospital provider agencies.
 - e. Area hospitals.

3. This protocol shall remain in effect for the duration of the declared Local Medical Emergency or until rescinded by the County Health Officer (Operational Area Medical Coordinator) or his/her designee.

MEDICAL CONTROL

1. ALS, Limited ALS, and BLS personnel may function within their Scope of Practice as established in the standard Practice Protocols without Base Station contact.
2. No care will be given unless the scene is secured and safe for EMS personnel.
3. An MCI will be initiated by either Comm Center or ICEMA. Patient destination will be determined as part of the MCI.
4. Transporting agencies may utilize BLS units for patient transport as dictated by transport resource availability. In cases where no ambulance units are available, personnel will utilize the most appropriate method of transportation at their disposal.
5. Patients too unstable to be transported outside the affected area should be transferred to the closest secured appropriate facility.
6. County Communications Center should be contacted on the MED NET frequency for patient destination by the transporting unit.
7. Base Station contact criteria outlined in protocol #5040, Radio Communication, may be suspended by the ICEMA Medical Director. EMS provider agencies will be notified. Receiving facilities should be contacted with following information once enroute:
 - a. ETA.
 - b. Number of patients.
 - c. Patient status: Immediate, delayed or minor.
 - d. Brief description of injury.
 - e. Treatment initiated.

DOCUMENTATION

First responder and transporting agencies may utilize approved triage tags as the minimum documentation requirement. The following conditions will apply:

1. One corner to be kept by the jurisdictional public safety agency. A patient transport log will also be kept indicating time, incident number, patient number (triage tag), and receiving facility.
2. One corner to be retained by the transporting agency. A patient log will also be maintained indicating time, incident number, patient number (triage tag) and receiving facility.
3. Remaining portion of triage tag to accompany patient to receiving facility which is to be entered into the patient's medical record.
4. All Radio Communication Failure reports may be suspended for duration of the Local Medical Emergency.

All refusals of treatment and/or transport will be documented as scene safety allows.

COUNTY COMMUNICATIONS CENTER

County Communications Center will initiate a MCI according to ICEMA policies. This information will be coordinated with appropriate fire/rescue zone dispatch centers and medical unit leaders in the field as needed.

RESPONSIBILITIES OF THE RECEIVING FACILITIES

1. Receiving facilities upon notification by the County Communications Center of a declared Local Medical Emergency will provide hospital bed availability and Emergency Department capabilities for immediate and delayed patients.
2. Receiving facilities will utilize ReddiNet to provide the County Communications Center and ICEMA with hospital bed capacity status every four (4) hours, upon request, or when capacities are reached.
3. It is strongly recommended that receiving facilities establish a triage area in order to evaluate incoming emergency patients.
4. In the event that incoming patients overload the service delivery capacity of the receiving hospital, it is recommended that the hospital consider implementing their disaster plan.
5. Saturated hospitals may request evacuation of stable in-patients. Movement of these patients should be coordinated by County Communications Center and in accordance with Armed Services Medical Regulation Office (ASMRO) system categories.



APPLYING PATIENT RESTRAINTS GUIDELINES

PURPOSE

To provide guidelines on the use of restraints in the field or during transport for patients who are violent or potentially violent, or who may harm themselves or others.

AUTHORITY

California Code of Regulations, Title 22, Sections 1000075 and 10000159. Welfare and Institutions Code 5150. California Administrative Code, Title 13, Sections 1103.2 Health and Safety Code, Section 1798.6.

PRINCIPLES

1. The safety of the patient, community and responding personnel is of paramount concern when following this policy.
2. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others.
3. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders.
4. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.
5. Restraints should be applied by law enforcement whenever possible. If applied, an officer is required to remain available at the scene or during transport to remove or adjust the restraints for patient safety.
6. This policy is not intended to negate the need for law-enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene-management control.

PROCEDURE

The following procedures should guide EMS personnel in the application of restraints and the monitoring of the restrained patient:

1. Restraint equipment must be either padded leather restraints or soft restraints (e.g., posey, Velcro or seat-belt type). Both methods must allow for quick release.
2. EMS personnel shall **not** apply following forms of restraint:
 - a. Hard plastic ties, any restraint device requiring a key to remove, hand cuffs or hobble restraints.
 - b. Backboard, scoop stretcher or flat as a "sandwich" restraint.
 - c. Restraining a patient's hands and feet behind the patient (e.g., hog-tying).
 - d. Methods or other materials applied in a manner that could cause vascular or neurological compromise.
3. Restraint equipment applied by law enforcement (handcuffs, plastic ties or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest, and to take full tidal volume breaths.
4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene-management safety. The officer shall accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.
5. Patients should be transported in a supine position if at all possible. EMS personnel must ensure that the patient's position does not compromise respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
6. Restrained patients shall be transported to the most appropriate receiving facility within the guidelines of Protocol Reference #9030 AEMT, Responsibility for Patient Management. The only allowable exception is a 5150 order presented when direct admission to a psychiatric facility has been arranged.

DOCUMENTATION

Documentation on the patient care form shall include:

1. The reasons restraints were needed.
2. Which agency applied the restraints (e.g., EMS, law enforcement).

3. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve and motor function every fifteen (15) minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation, and may be difficult to monitor.
4. Respiratory status should be evaluated for rate and quality every fifteen (15) minutes or more often as clinically indicated while restrained.



CARE OF MINORS IN THE FIELD

PURPOSE

To provide guidelines for EMS personnel for treatment and/or transport of minors in the field.

AUTHORITY

California Welfare and Institutions Code Section 625, Civil Code, sections 25, 34 and 62

DEFINITIONS

Consent: Except for circumstances specifically prescribed by law, a minor is not legally competent to consent to, or refuse medical care.

Voluntary consent: Treatment and/or transport of a minor shall be with the verbal or written consent of the parent or legal representative.

Involuntary consent: In the absence of a parent or legal representative, emergency treatment and/or transport may be initiated without consent.

Minor: Any person under eighteen (18) years of age.

Minor not requiring parental consent: A person who is decreed by the court as an emancipated minor, has a medical emergency and parent is not available, is married or previously married, is on active duty in the military, is pregnant and requires care related to the pregnancy, is twelve (12) years or older and in need of care for rape and/or sexual assault, is twelve (12) years or older and in need of care for a contagious reportable disease or condition, or for substance abuse.

Legal Representative: A person who is granted custody or conservatorship of another person.

Emergency: An unforeseen condition or situation in which the individual has need for immediate medical attention, or where the potential for immediate medical attention is perceived by EMS personnel or a public safety agency

PROCEDURE

Treatment and/or Transport of Minor

1. For all ill or injured minors under the age of nine (9) years, Base Station contact is required before leaving scene.
2. In the absence of a parent or legal representative, minors with an emergency condition shall be treated and transported to the medical facility most appropriate to the needs of the patient.
3. In the absence of a parent or legal representative, minors with a non-emergency condition require EMS personnel to make reasonable effort to contact a parent or legal representative before initiating treatment and/or transport. If a parent or legal representative cannot be reached and minor is transported, EMS personnel shall make every effort to inform the parent or legal representative of where the minor has been transported, and request that law enforcement accompany the minor patient to the hospital.

Minor Not Requiring Immediate Treatment and/or Transport

1. A minor evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have an illness or injury not requiring immediate treatment and/or transportation, may be released to:
 - a. Parent or legal representative.
 - b. Designated care giver over eighteen (18) years of age.
 - c. Law Enforcement.
2. EMS personnel shall document on the patient care record to whom the minor was released.

Minor Attempting to Refuse Indicated Care

1. Contact Base Station.
2. Attempt to contact parent or legal representative for permission to treat and/or transport.
3. Contact Law Enforcement and request minor to be taken into temporary custody for treatment and/or transport (only necessary in the event parents or legal representative cannot be contacted).



PATIENT REFUSAL OF CARE GUIDELINES - ADULT

PURPOSE

To provide guidance for EMS Personnel whose advice to an individual for treatment and/or transport is being refused.

AUTHORITY

Health and Safety Code, Section 1797.220

PRINCIPLE

Recognizing that the decision to be transported by a provider agency is solely the responsibility of the individual, a process should be in place to document such "refusal of services", to protect both the individual and EMS personnel. An AMA should be initiated whenever the highest medical authority on scene determines that a person would benefit from assessment, treatment and/or transport and that person refuses.

DEFINITIONS

AMA: A term used to designate "against medical advice".

Consent: Consent is defined as the agreement and acceptance as to opinion or course of action.

Emergency: The American Ambulance Association (AAA) defines an "emergency" as "unforeseen condition of a pathophysiological nature, which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention".

CONSENT

1. Legal consent procedures should not delay immediately required treatment.
2. An individual has the responsibility to consent to or refuse treatment. If he/she is unable to do so consent is then considered implied.
3. In non-emergency cases, consent should be obtained from the individual.

4. For treatment of minors or a definition of emancipated minors refer to Protocol Reference #9080 AEMT Care of Minors in the Field.

MENTAL COMPETENCE

1. An individual is mentally competent if he or she:
 - a. Is capable of understanding the nature and consequences of the proposed treatment.
 - b. Has sufficient emotional control, judgment and discretion to manage his or her own affairs.
2. An individual having an understanding of what may happen if treated or not treated, and is oriented to person, place, time and purpose.
3. An individual with an altered level of consciousness will be unlikely to fulfill these criteria.
4. If the individual is not deemed mentally competent, the person should be treated and transported. It is preferable under such circumstances to obtain concurrence of a police officer in this course of action.

REFUSAL OF CARE DOCUMENTATION

In accordance with these guidelines, the following should be carefully documented on the patient care record:

1. The individual's chief complaint, mechanism of injury, level of orientation/level of consciousness.
2. Base Station Contact per Protocol Reference #5040, Radio Communication.
3. Any medical treatment or evaluation needed and refused.
4. The need for emergency transportation; also if transport by means other than an ambulance could be hazardous due to the individual's injury or illness.
5. Individual advised that potential harm could result without emergency medical treatment and/or transport.
6. Individual provided with a refusal advice sheet, and if he or she would accept the refusal advice sheet.

7. A copy of the patient care record with the individual's signature of refusal will be kept by the EMS provider agency per Protocol Reference #2010, Requirements for Patient Care Records.



KING AIRWAY DEVICE (PERILARYNGEAL) - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Use of the King Airway adjunct may be performed only on those patients who meet **ALL** of the following criteria:

1. Unresponsive and apneic (less than 6 breaths per minute).
2. No gag reflex.
3. Anyone over four (4) feet in height
 - a. 4-5 feet: Size 3 (connector color: yellow)
 - b. 5-6 feet: Size 4 (connector color: red)
 - c. 6 feet and over: Size 5 (connector color: purple)

ADDITIONAL CONSIDERATIONS

1. BVM management not adequate or effective.
2. A King Airway adjunct should not be removed unless there is a malfunction.
3. Medications may **NOT** be given via the King Airway.

CONTRAINDICATIONS

1. Conscious patients with an intact gag reflex.
2. Known ingestion of caustic substances.
3. Suspected foreign body airway obstruction (FBAO).
4. Facial and/or esophageal trauma.
5. Patients with known esophageal disease (cancer, varices, surgery, etc.).

PROCEDURE

1. Using the information provided, choose the correct KING LTS-D size based on patient height.
2. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 3 – 60 ml; size 4 – 80 ml; size 5 – 90 ml). Prior to insertion, disconnect Valve Actuator from Inflation Valve and remove all air from both cuffs.
3. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube taking care to avoid introduction of lubricant in or near the ventilatory openings.
4. Have a spare KING LTS-D ready and prepared for immediate use.
5. Pre-oxygenate.
6. Position the head. (The ideal head position for insertion of the KING LTS-D is the “sniffing position”.)
7. Hold the KING LTS-D at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.
8. With the KING LTS-D rotated laterally 45-90°, introduce tip into mouth and advance behind base of tongue.
9. Rotate the tube back to the midline as the tip reaches the posterior wall of the pharynx.
10. Without exerting excessive force, advance KING LTS-D until base of connector is aligned with teeth or gums.
11. Holding the KLT 900 Cuff Pressure Gauge in non-dominant hand, inflate cuffs of the KING LTS-D to 60 cm H₂O. If a cuff pressure gauge is not available and a syringe is being used to inflate the KING LTS-D, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (just seal volume).
12. Attach the breathing circuit to the 15 mm connector of the KING LTS-D. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

13. Reference marks are provided at the proximal end of the KING LTS-D which when aligned with the upper teeth give an indication of the depth of insertion.
14. Confirm proper position by auscultation and chest movement.
15. Readjust cuff inflation to 60 cm H₂O (or to just seal volume).
16. Secure KING LTS-D to patient.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, an incident Report must be completed by the receiving hospital and forwarded to ICEMA within twenty-four (24) hours of the incident. Forms are available as part of the protocol manual and on the ICEMA website.



KING AIRWAY DEVICE (PERILARYNGEAL) – PEDIATRIC (Less than 15 years of age)

FIELD ASSESSMENT/TREATMENT INDICATORS

Use of the King Airway adjunct may be performed only on those patients who meet **ALL** of the following criteria:

1. Unresponsive and apneic (less than 6 per minute).
2. No gag reflex.
3. Pediatric patients meeting the following criteria:
 - a. 35-45 inches or 12-25 kg: Size 2 (connector color: green)
 - b. 41-51 inches or 25-35 kg: Size 2.5 (connector color: orange).

ADDITIONAL CONSIDERATIONS

1. BVM management not adequate or effective.
2. A King Airway adjunct should not be removed unless there is a malfunction.
3. Medications may **NOT** be given via the King Airway.

CONTRAINDICATIONS

1. Conscious patients with an intact gag reflex.
2. Known ingestion of caustic substances.
3. Suspected foreign body airway obstruction (FBAO).
4. Facial and/or esophageal trauma.
5. Patients with known esophageal disease (cancer, varices, surgery, etc.).

PROCEDURE

1. Using the information provided, choose the correct KING LT size based on patient height.
2. Test cuff inflation system by injecting the maximum recommended volume of air into the cuffs (size 2: 25–35 ml; size 2.5: 30-40 ml). Prior to insertion, disconnect Valve Actuator from Inflation Valve and remove all air from both cuffs.
3. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube taking care to avoid introduction of lubricant in or near the ventilatory openings.
4. Have a spare KING LT ready and prepared for immediate use.
5. Pre-oxygenate.
6. Position the head. (The ideal head position for insertion of the KING LT is the “sniffing position.”)
7. Hold the KING LT at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift.
8. With the KING LT rotated laterally 45-90°, introduce tip into mouth and advance behind base of tongue.
9. Rotate the tube back to the midline as the tip reaches the posterior wall of the pharynx.
10. Without exerting excessive force, advance KING LT until base of connector is aligned with teeth or gums.
11. Holding the KLT 900 Cuff Pressure Gauge in non-dominant hand, inflate cuffs of the KING LT to 60 cm H₂O. If a cuff pressure gauge is not available and a syringe is being used to inflate the KING LT, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed (just seal volume).
12. Attach the breathing circuit to the 15 mm connector of the KING LT. While gently bagging the patient to assess ventilation, simultaneously withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

13. Reference marks are provided at the proximal end of the KING LT which when aligned with the upper teeth give an indication of the depth of insertion.
14. Confirm proper position by auscultation and chest movement.
15. Readjust cuff inflation to 60 cm H₂O (or to just seal volume).
16. Secure KING LT to patient.

DOCUMENTATION

In the event the receiving physician discovers the device is improperly placed, attached is an Incident Report that must be filled out and forwarded to ICEMA within one (1) week by the receiving hospital.



AUTOMATIC EXTERNAL DEFIBRILLATION (AED) - BLS

PURPOSE

To identify guidelines for the use of the AED for all patients one (1) year of age or older in cardiac arrest. The overall goal of the AED program is to provide for rapid defibrillation and transfer of patients to an ALS provider as quickly as possible.

FIELD ASSESSMENT/TREATMENT INDICATORS

All of the following criteria must be met prior to applying the AED machine:

1. Unresponsive, pulseless and apneic ("gaspings" breaths).
2. One (1) year of age or older.
3. Have an apparent body temperature greater than 86 degrees F.

If patient meets the criteria per Protocol Reference #12010, Determination of Death, or Protocol Reference #12020, Withholding Resuscitation, AED application is not indicated.

PROCEDURE

1. Initiate immediate CPR.
2. Power on the AED.
3. Place appropriate pads according to manufacturer's guidelines. If the AED is equipped with a pediatric attenuator, it should be utilized for children between one (1) and nine (9) years of age. CPR is not to be interrupted except briefly for rhythm assessment.
4. Analyze rhythm.
 - a. If shocks are required, each shock should be immediately followed by two (2) minutes of CPR.
 - b. If additional shocks are not required:
 - i. If patient begins to move, maintain appropriate airway and oxygenation; obtain and monitor vital signs throughout care.

- ii. If patient remains unresponsive, pulseless and apneic, continue CPR for two (2) minutes and reanalyze.
5. Continue care as indicated by patient condition until ALS providers assume care or patient starts to move.
6. BLS agencies may only transfer care to a provider of equal or greater level. If a BLS transport agency is not an approved AED service provider, the AED personnel must accompany the patient with the appropriate equipment.

DOCUMENTATION AND QUALITY IMPROVEMENT

1. BLS agencies shall complete an ICEMA approved patient care report form and data collection device per Protocol Reference #2010, Requirements for Patient Care Records.
2. PS-D agencies must provide documentation on ICEMA approved form.
3. Use of the AED shall be evaluated by the provider agency through their QI Plan. All data will be used to compile their annual report to ICEMA.

SPECIAL NOTE

AED units should be programmed to the latest 2010 AHA Guidelines for CPR and Emergency Cardiac Care standards for defibrillation for adults and pediatrics no later than December 31, 2011. Until personnel and equipment have been updated to the new guidelines, agencies should continue to perform CPR as trained and follow the AED prompts as directed.



AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to the following:

1. Patient meets Mechanism of injury.
2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles.
3. Unconscious patients where the mechanism of injury is unknown.
4. All intubated neonatal and pediatric patients.
5. Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.
6. Altered mental status.
7. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).
8. Additional sites of significant distracting pain or is experiencing emotional distress.
9. Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.
10. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.
11. Any other condition that may reduce the patient's perception of pain.

INTERVENTIONS

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients: If the level of the patient's head is greater than that of the

- torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.
 5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.
 6. When a pregnant patient in the third trimester is placed in axial spinal stabilization, place in the left lateral position to decrease pressure on the Inferior Vena Cava.
 7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

LIMITED ALS INTERVENTIONS

Limited ALS personnel may remove patients placed in axial spinal stabilization by Emergency Medical Responders and BLS personnel if the patient does not meet **any** of the above indicators after a complete assessment and documentation on the patient care record:



ADULT RESPIRATORY EMERGENCIES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

FIELD ASSESSMENT/TREATMENT INDICATORS

Chronic symptoms of pulmonary disease, wheezing, cough, pursed lip breathing, decreased breath sounds. Accessory muscle use, anxiety, ALOC or cyanosis.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, obtain O₂ saturation on room air, or on home O₂ if possible.

LIMITED ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home O₂ if possible.
2. Nebulized Albuterol 2.5mg, with Atrovent 0.5mg may repeat times two (2).

ACUTE ASTHMA/BRONCHOSPASM

FIELD ASSESSMENT/TREATMENT INDICATORS

History of prior attacks, associated with wheezing, diminished breath sounds, or cough. A history of possible toxic inhalation, associated with wheezing, diminished breath sounds, or cough. Suspected allergic reaction associated with wheezing, diminished breath sounds or cough.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, humidified oxygen preferred.

LIMITED ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
2. Nebulized Albuterol 2.5mg, with Atrovent 0.5mg may repeat times two (2).
3. For signs of inadequate tissue perfusion, initiate IV bolus of 300cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
4. If no response to Albuterol, give Epinephrine 0.3mg (1:1,000) SC. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
5. May repeat Epinephrine 0.3mg (1:1,000) SQ after 15 minutes.
6. Base station physician may order additional medications or interventions as indicated by patient condition.

ACUTE PULMONARY EDEMA/CHF**FIELD ASSESSMENT/TREATMENT INDICATORS**

History of cardiac disease, including CHF, and may present with rales, occasional wheezes, jugular venous distention and/or peripheral edema.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask.
3. Be prepared to support ventilations as clinically indicated.

LIMITED ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, Obtain O₂ saturation on room air if possible
2. Nitroglycerine 0.4mg sublingual/transmucosal with signs of adequate tissue perfusion. May be repeated as long as patient continues to have signs of adequate tissue perfusion. Do not use or discontinue NTG in presence of hypotension (SBP <100).

3. Nebulized Albuterol 2.5 mg, with Atrovent 0.5 mg may repeat times two (2), if nitro is not working.



AIRWAY OBSTRUCTION - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Universal sign of distress.
2. Alteration in respiratory effort and/or signs of obstruction.
3. Altered level of consciousness.

BLS INTERVENTION - RESPONSIVE

1. Assess for ability to speak or cough (e.g. "Are you choking?").
2. If unable to speak, administer abdominal thrusts/Heimlich maneuver or chest thrusts for pregnant or obese patients until the obstruction is relieved or patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC's.
4. Administer oxygen therapy; if capable obtain O2 saturation, per Protocol Reference #10170, Pulse Oximetry.
5. If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

BLS INTERVENTION - UNRESPONSIVE

1. Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
2. Open airway with, head tilt-chin lift (for suspected trauma use jaw thrust). Remove object if visible. Assess for presence and/or effectiveness of respiration for no more than ten (10) seconds.
3. If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise, reposition airway and reattempt.
4. If apneic and able to ventilate, provide one (1) breath every five (5) to six (6) seconds.

5. If unable to ventilate, check for pulse then initiate CPR according to AHA 2005 guidelines and check for pulse every two (2) minutes until obstruction is relieved or able to ventilate.
6. If available, place AED per Protocol Reference #10130 AEMT.

LIMITED ALS INTERVENTION – UNRESPONSIVE

1. If apneic and able to ventilate, establish advanced airway.
2. Establish vascular access as indicated.



NON-TRAUMATIC HYPERTENSIVE CRISIS

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Headache, blurred vision.
2. Neurological deficit.
3. Altered level of consciousness.
4. Chest pain, dyspnea.
5. Pulmonary edema.
6. Abrupt elevation of diastolic blood pressure.

CONTRAINDICATIONS

Nitroglycerin is contraindicated for use in a hypertensive crisis of unknown etiology.

BLS INTERVENTIONS

1. Reduce anxiety; allow patient to assume position of comfort and elevate head slightly.
2. Administer oxygen as clinically indicated; prepare to support ventilations as clinically indicated.
3. Consider transport to closest hospital or ALS intercept.

LIMITED ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts.
2. Obtain oxygen saturation on room air, if possible, unless detrimental to patient condition.
3. Obtain vascular access -- saline lock preferred.
4. Contact Base Station.



SUSPECTED ACUTE MI

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Chest Pain (Typical or Atypical).
2. Syncopal episode.
3. History of previous AMI, Angina, Heart Disease, or other associated risk factors.

BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI.
2. Reduce anxiety, allow patient to assume position of comfort.
3. O₂ as clinically indicated.
4. Obtain Oxygen saturation.
5. May assist patient with self-administration of Nitroglycerin and Aspirin.

LIMITED ALS INTERVENTIONS

1. Aspirin 162mg.
2. Consider early vascular access.
3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300ml NS bolus, may repeat.
4. Nitroglycerin 0.4mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. Nitroglycerin is contraindicated (signs of inadequate tissue perfusion or recent use of sexual enhancement medications).
5. Consider establishing a saline lock enroute on same side as initial IV.
6. Complete thrombolytic checklist, if time permits.
7. Contact Base Station.



CARDIAC ARREST - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

BLS INTERVENTIONS

1. Assess patient, begin CPR according to current AHA Guidelines and maintain appropriate airway.
 - a. Compression rate shall be 100/minute utilizing 30:1 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
 - b. Ventilatory volumes shall be sufficient to cause adequate chest rise.
2. Place AED and follow Protocol Reference #10130 AEMT. CPR is **not** to be interrupted except briefly for rhythm assessment.

LIMITED ALS INTERVENTIONS

1. Initiate CPR while applying the AED.
2. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.
3. Establish peripheral intravenous access and administer a 300ml bolus, with signs and symptoms of inadequate tissue perfusion, may repeat fluid bolus.
4. Reference Protocol 12010 AEMT Determination of Death policy.

Utilize the following treatment modalities while managing the cardiac arrest patient:

1. Obtain blood glucose, if indicated; administer Dextrose 50% 25gms IV.
2. Naloxone 2.0mg IM/IN for suspected opiate overdose.

NOTE

Base station contact is required to terminate resuscitative measures.



ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Patient exhibiting signs/symptoms of a possible altered level of consciousness.
2. Suspected narcotic dependence, overdose, hypoglycemia, traumatic injury, shock and alcoholism.
3. Tonic/clonic movements followed by a brief period of unconsciousness (post-ictal).
4. Suspect status epilepticus for frequent or extended seizures.

BLS INTERVENTIONS

1. Oxygen therapy as clinically indicated.
2. Position patient as tolerated. If altered gag reflex in absence of traumatic injury, place in left lateral position.
3. Place patient in axial spinal stabilization if trauma is suspected.
4. If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

LIMITED ALS INTERVENTIONS (ADULT)

1. Obtain vascular access.
2. Obtain blood glucose. If hypoglycemic administer:
 - a. Dextrose 25 Grams (50cc) IV of 50% solution, or
 - b. Glucagon 1mg IM/SC/IN, if unable to establish IV. May give one (1) time only.
 - c. May repeat blood glucose. Repeat Dextrose if extended transport time.
3. If suspected narcotic overdose administer:

- a. Naloxone 2mg IM/IN.
 - b. Repeat Naloxone 2mg IM/IN every 2-3 minutes if needed.
4. Assess and document response to therapy.
 5. Base Station may order additional medication dosages and fluid bolus.

LIMITED ALS INTERVENTIONS (PEDIATRIC)

1. Obtain vascular access.
2. Obtain blood glucose.
3. Glucagon 0.5mg IM/IN < 1year of age.
4. Glucagon 1.0mg IM/IN > 1 year of age.
5. Naloxone 0.1mg/kg IM/IN (maximum of 2mg). Repeat dose ever 2-3minutes.



BURNS – ADULT 15 Years of Age and Older

Any burn patient meeting Burn Classifications requires expeditious packaging, communication and transportation to the closest most appropriate receiving hospital.

FIELD ASSESSMENT/TREATMENT INDICATORS

Burn Criteria and Destination Policy #8030

ADULT TREATMENT PROTOCOL: BURNS

Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> • Assess environment and extrication as indicated • Break contact with causative agent (stop the burning process) • Ensure patient airway, protecting cervical spine as indicated • Remove clothing and jewelry quickly, if indicated • Ensure initial assessment • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Axial spinal stabilization as appropriate • Treat other life threatening injuries • Control obvious bleeding • Keep patient warm • Estimate % TBSA burned and depth using the “Rule of Nines” <ul style="list-style-type: none"> ○ An individual’s palm represents 1% of TBSA and can be used to estimate scattered, irregular burns • Transport to ALS intercept or to the closest most appropriate receiving hospital • Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances 	<ul style="list-style-type: none"> • Advanced airway as indicated <p>Airway Stabilization: Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.</p> <ul style="list-style-type: none"> • Monitor ECG • IV Access: Warm IV fluids when avail <p><i>Unstable:</i> BP<90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.</p> <ul style="list-style-type: none"> ○ IV NS 250ml boluses, may repeat to a maximum of 1000ml. <p><i>Stable:</i> BP>90mmHG and/or signs of adequate tissue perfusion.</p> <ul style="list-style-type: none"> ○ IV NS 500ml/hour

<u>BLS Continued</u>	<u>Limited ALS Continued</u>
MANAGE SPECIAL CONSIDERATIONS:	MANAGE SPECIAL CONSIDERATIONS:
Thermal Burns: Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.	<ul style="list-style-type: none">• Transport to appropriate facility: <i>Minor Burn Classification:</i> transport to the closest most appropriate receiving hospital. <i>Moderate Burn Classification:</i> transport to the closest most appropriate receiving hospital. <i>Major Burn Classification:</i> transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC). <i>CTP with associated burns:</i> transport to the most appropriate trauma hospital.• Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be considered for transport to the closest most appropriate Burn Center. Trauma base station contacted shall be made.
Chemical Burns: Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.	Electrical Burns: Place AED according to ICEMA protocols. <ul style="list-style-type: none">• Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
Tar Burns: Cool with water, do not remove tar.	
Electrical Burns: Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.	

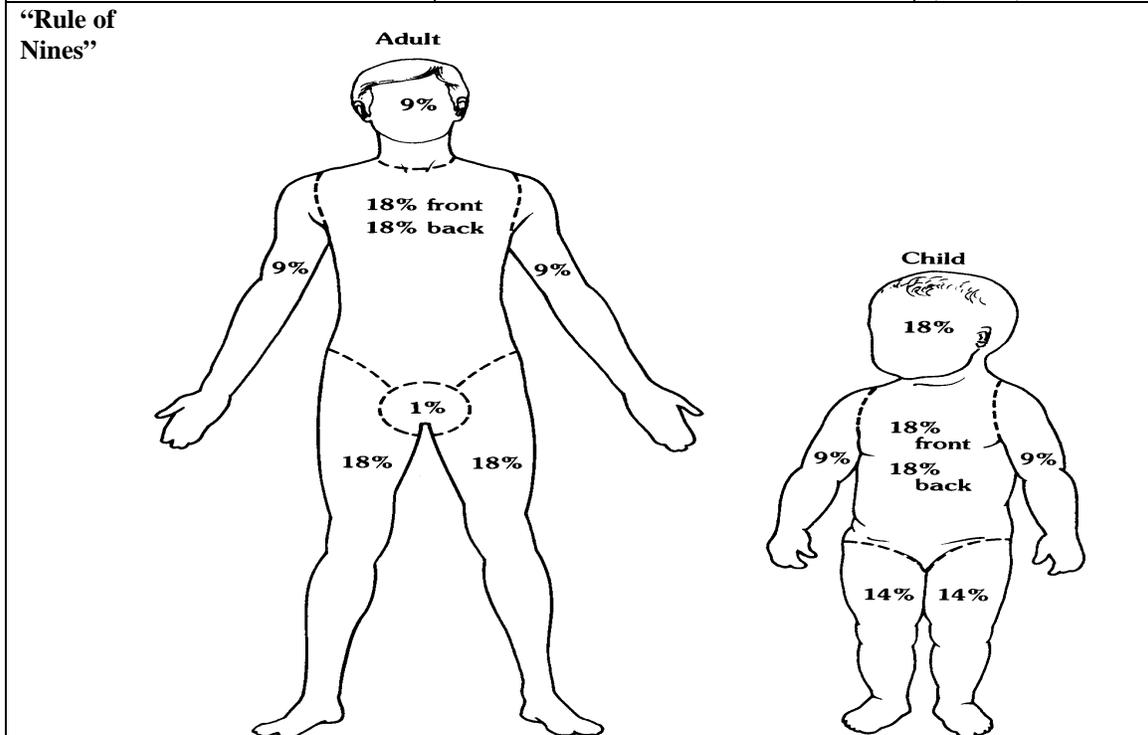
<u>BLS Continued</u>	<u>Limited ALS Continued</u>
<p>Eye Involvement: Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.</p>	<p>Respiratory Distress: Place an Advanced Airway if the patient presents facial/oral swelling or if respiratory depression or distress develops due to inhalation injury.</p> <ul style="list-style-type: none"> • Nebulized Albuterol 2.5mg with Atrovent 0.5mg, may repeat two (2) times.
<p>Determination of Death on Scene: Refer to Protocol # 12010 AEMT, Determination of Death on Scene.</p>	<p>Deteriorating Vital Signs: Transport to the closest most appropriate receiving hospital. Contact base station.</p>
	<p>Pulseness and Apneic: Transport to the closest most appropriate receiving hospital and treat according to ICEMA policies. Contact base station.</p>
	<p>Determination of Death on Scene: Refer to Reference Protocol # 12010 AEMT, Determination of Death on Scene.</p>
	<p>Precautions and Comments:</p> <ul style="list-style-type: none"> • High flow oxygen is essential with known or potential respiratory injury. Beware of possible smoke inhalation. • Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact. • Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
	<p>Base Station Orders: May order additional:</p> <ul style="list-style-type: none"> • medications; • fluid boluses.

REFERENCE PROTOCOLS

<u>Protocol Number</u>	<u>Protocol Name</u>
9010 AEMT	General Patient Care Guidelines
10160 AEMT	Axial Spinal Stabilization
10010/10020 AEMT	King Airway Device
11070 AEMT	Adult Cardiac Arrest
15030 AEMT	Trauma Triage Criteria and Destination Policy
12010 AEMT	Determination of Death on Scene

BURN CLASSIFICATIONS

ADULT BURN CLASSIFICATION CHART	PEDIATRIC BURN CLASSIFICATION CHART	DESTINATION
<p><u>MINOR</u> – ADULT</p> <ul style="list-style-type: none"> • < 10% TBSA • < 2% Full Thickness 	<p><u>MINOR</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • < 5% TBSA • < 2% Full Thickness 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>
<p><u>MODERATE</u> – ADULT</p> <ul style="list-style-type: none"> • 10 - 20% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p><u>MODERATE</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • 5 – 10% TBSA • 2 – 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>
<p><u>MAJOR</u> – ADULT</p> <ul style="list-style-type: none"> • >20% TBSA burn in adults • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints 	<p><u>MAJOR</u> - PEDIATRIC</p> <ul style="list-style-type: none"> • > 10% TBSA • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints 	<p>CLOSEST MOST APPROPRIATE BURN CENTER</p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>





WITHHOLDING RESUSCITATIVE MEASURES

PURPOSE

To establish criteria for withholding resuscitative measures from person(s) who do not otherwise meet the “Determination of Death” criteria in the prehospital setting and/or during interfacility transport.

AUTHORITY

Division 2.5, Sections 1797.220 and 1798 of the California Health and Safety Code.

POLICY

The DNR only applies to cardiopulmonary resuscitative measures. An order not to resuscitate is not an order to withhold other necessary medical treatment or nutrition. The treatment given to a patient with a DNR agreement should in all respects be the same as that provided to a patient without such an agreement.

DEFINITIONS

Do Not Resuscitate (DNR): A written order by a physician or the presence of a DNR medallion/bracelet or necklace indicating that an agreement has been reached between the physician and patient/or surrogate that in the event of cardiac or respiratory arrest the following medical interventions will **NOT** be initiated:

1. Chest compressions,
2. Defibrillation,
3. Endotracheal intubation,
4. Assisted ventilation,
5. Cardiotonic drugs, e.g., epinephrine, atropine or other medications intended to treat a non-perfusing rhythm.

Absent vital signs: Absence of respiration and absence of carotid pulse.

DNR medallion/bracelet/necklace: A medallion/bracelet/necklace worn by a patient, which has been approved for distribution by the California Emergency Medical Services Authority (EMSA).

Prehospital DNR form: Form developed by the California Medical Association (CMA) for use statewide for prehospital DNR requests. This form has been approved by EMSA and ICEMA. This form should be available to prehospital personnel in the form of the white original DNR form or as a photocopy. The original or copy of the DNR form will be taken with the patient during transport. **The DNR form shall not be accepted if amended or altered in any way.**

Prehospital Personnel: Any EMS field responder currently certified and/or accredited in San Bernardino, Inyo or Mono Counties.

Physician Orders for Life-Sustaining Treatment (POLST): A physician's order that outlines a plan of care reflecting the patient's wishes concerning care at life's end. The POLST form is voluntary and is intended to assist the patient and their family with planning and developing a plan to reflect the patient's end of life wishes. It is also intended to assist physicians, nurses, health care facilities and emergency personnel in honoring a person's wishes for life-sustaining treatment.

VALIDATION CRITERIA

1. **Statewide Prehospital DNR Form** (Appendix A) should include the following to be considered valid:
 - a. Patient's name.
 - b. Signature of the patient or a legal representative if the patient is unable to make or communicate informed health care decisions.
 - c. Signature of patients' physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
 - d. All signatures are to be dated.
 - e. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.
2. **DNR medallion/bracelet/necklace:** The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:

- a. Patient must be physically wearing the DNR medallion/bracelet/necklace.
 - b. Medallion/bracelet/necklace must be engraved with the words “Do Not Resuscitate EMS”, along with a toll free emergency information telephone number and a patient identification number.
3. **Physician DNR orders:** In licensed health care facilities a DNR order written by a physician shall be honored. The staff must have the patient’s chart with the DNR order immediately available for EMS personnel upon their arrival.
 4. **POLST:** The POLST form must be signed and dated by a physician. **Without this signature, the form is invalid.** Verbal or telephone orders are valid if allowed by the institution or facility. There should be a box checked indicating who the physician discussed the POLST orders with. By signing the form, the physician acknowledges that these orders reflect the wishes of the patient or designated decision maker.

PROCEDURE

1. EMS personnel shall validate the DNR request or POLST form.
2. BLS personnel shall continue resuscitative measures if a DNR or POLST cannot be validated.
3. Limited ALS personnel shall contact a Base Station for direction if a DNR or POLST cannot be validated. While Limited ALS personnel are contacting the Base Station for direction, BLS treatment must be initiated. If contact cannot be made, resuscitative efforts shall continue.
4. If a patient states he/she wishes resuscitative measures, the request shall be honored.
5. If a family member requests resuscitative measures despite a valid DNR or POLST, continue resuscitative measures until Base Station contact is made.
6. If patient is not in cardiac arrest and has a valid POLST form, EMS may provide comfort measures as described in section B of the form.
7. The patient shall be transported to the hospital if comfort measures are started by EMS.
8. Any questions about transporting the patient will be directed to the Base Station.
9. If a patient expires at home, law enforcement must be notified.

10. If a patient expires in a licensed health care facility, the facility has the responsibility to make the appropriate notification.
11. All circumstances surrounding the incident shall be documented on the patient care record. If prehospital personnel are unable to copy the DNR or POLST form the following shall be documented on the patient care record:
 - a. Presence of DNR or POLST form.
 - b. Date of order.
 - c. Name of physician who signed form.
12. A copy of the patient care report and DNR or POLST must be forwarded to ICEMA within one (1) week by either the PLN at the receiving facility if it is a Base Station or by the EMT-P's Agency EMS/QI Coordinator.

SUPPORTIVE MEASURES

1. Medical interventions that may provide for the comfort, safety and dignity of the patient should be utilized.
2. The patient should receive palliative treatment for pain, dyspnea, major hemorrhage or other medical conditions.
3. Allow any family members/significant others to express their concerns and begin their grieving process.



POISONINGS

PRIORITIES

1. Assure the safety of EMS personnel.
2. Assure and maintain ABCs.
3. Determine degree of physiological distress.
4. Obtain vital signs, history and complete physical assessment including the substance ingested, the amount, the time substance was ingested and the route.
5. Bring ingested substance to the hospital with patient.
6. Expeditious transport.

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Altered level of consciousness.
2. Signs and symptoms of substance ingestion, inhalation, injection or surface absorption.
3. History of substance poisoning.

DEFINITIVE CARE

1. Assure and maintain ABCs.
2. Place patient on high flow oxygen as clinically indicated.
3. Contact poison control (1-800-222-1222).
4. Obtain accurate history of incident:
 - a. Name of product or substance.
 - b. Quantity ingested, and/or duration of exposure.

- c. Time elapsed since exposure.
 - d. Pertinent medical history, chronic illness, and/or medical problems within the last 24 hours.
 - e. Patient medication history.
5. Monitor vital signs.
 6. Expeditious transport.

LIMITED ALS SUPPORT PRIOR TO BASE STATION CONTACT

1. Assure and maintain ABC's.
2. Oxygen therapy as clinically indicated, obtain oxygen saturation on room air, unless detrimental to patient condition.
3. Obtain vascular access at a TKO rate or if hypotensive administer 500cc fluid challenge to sustain a systolic B/P greater than 90mmHg. For pediatric patients with a systolic B/P less than 80mmHg give 20cc/kg IVP and repeat as indicated.
4. Charcoal 50gms for adult (pediatrics 1gm/kg). Administer P.O. if alert with a gag reflex. Charcoal is contraindicated with caustic ingestions.



HEAT RELATED EMERGENCIES

MINOR HEAT ILLNESS SYNDROMES

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Environmental conditions.
2. Postural hypotension.
3. Dehydration.
4. Heat cramps.

BLS INTERVENTIONS

1. Remove patient from heat source, position with legs elevated and begin cooling measures.
2. Oxygen as clinically indicated.
3. Rehydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated.

HEAT EXHAUSTION

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Dehydration.
2. Elevated temperature, vomiting, hypotension, diaphoresis, tachycardia and tachypnea.
3. No change in LOC.

BLS INTERVENTIONS

1. Remove patient from heat source, position with legs elevated and begin cooling measures.

2. Oxygen as clinically indicated.
3. Rehydrate with small amounts of appropriate liquids as tolerated.
4. Axial-spinal stabilization if indicated.

LIMITED ALS INTERVENTIONS

1. Obtain vascular access.
 - a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains less than 90mmHg.
 - b. Pediatric patients less than nine (9) years of age: Initial 20cc/kg IV bolus; may repeat until palpable pulse obtained.
2. Obtain blood glucose and provide treatment as clinically indicated.
3. Base Station may order additional fluid boluses.

HEAT STROKE

FIELD ASSESSMENT/ TREATMENT INDICATORS

1. Hyperthermia.
2. ALOC or other signs of central nervous system dysfunction.
3. Absence or presence of sweating.
4. Tachycardia, Hypotension.

BLS INTERVENTIONS

1. Remove from heat source, position with legs elevated and begin cooling measures.
2. Rapid cooling measures including cold packs placed adjacent to large superficial vessels.
3. Evaporative cooling measures. Avoid oral intake if patient has altered level of consciousness.
4. Oxygen as clinically indicated.

LIMITED ALS INTERVENTIONS

1. Obtain vascular access.
 - a. Adult: Fluid bolus with 300cc NS. Reassess and repeat fluid bolus if BP remains less than 90mmHg.
 - b. Pediatric patients less than nine (9) years of age: Initial 20cc/kg IV bolus; may repeat until palpable pulse obtained.
2. Obtain blood glucose and provide treatment as clinically indicated.
3. Seizure precautions refer to Protocol Reference #11080 AEMT, Altered Level of Consciousness/Seizures, or Protocol Reference #14060 AEMT, Pediatric Seizure, if seizures occur.
4. Contact Base Station for destination and further treatment orders.



COLD RELATED EMERGENCIES

SUSPECTED FROSTBITE

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Areas of skin that are cold, white, and hard to touch.
2. Pain to affected extremity.

BLS INTERVENTIONS

1. Elevate extremity.
2. Do not rub or otherwise attempt active warming.
3. Protect affected body part from further exposure by wrapping in dry sterile gauze.

LIMITED ALS INTERVENTIONS

Obtain vascular access.

MILD HYPOTHERMIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Decreased core temperature.
2. Cold, pale extremities.
3. Shivering, reduction in fine motor skills.
4. Loss of judgment and/or altered level of consciousness or simple problem solving skills.

BLS INTERVENTIONS

1. Oxygen as clinically indicated.
2. Remove from cold/wet environment; remove wet clothing and dry patient.

3. Insulate and apply wrapped heat packs, if available, to groin, axilla and neck. This process should not be interrupted during transport.

LIMITED ALS INTERVENTIONS

1. Obtain vascular access. (Apply AED).
2. Consider blood glucose determination and provide treatment as clinically indicated.

SEVERE HYPOTHERMIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Severe cold exposure or any prolonged exposure to ambient temperatures below 36 degrees with the following indications:
 - a. Altered LOC with associated behavior changes.
 - b. Unconscious.
 - c. Lethargic.
2. Shivering is generally absent.
3. Blood pressure and heart sounds may be unobtainable.

BLS INTERVENTIONS

1. Maintain appropriate airway with oxygen as clinically indicated (warm, humidified if possible).
2. Assess carotid pulse for a minimum of 1-2 minutes. If no pulse palpable, place AED if available, per Protocol Reference #10130 AED. If no shock advised, begin CPR.
3. Insulate to prevent further heat loss.
4. Gently cut away wet clothing if transport time is greater than 30 minutes.

LIMITED ALS INTERVENTIONS

1. Advanced airway as clinically indicated.
2. Obtain vascular access and administer fluid bolus.

- a. Nine (9) years and older: 300ml warmed NS, may repeat.
 - b. Birth to eight (8) years: 20ml/kg warmed NS, may repeat.
3. Contact Base Station.



ALLERGIC REACTIONS – ANAPHYLAXIS

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Signs and Symptoms of an Acute Allergic Reaction.
2. History of Exposure to Possible Allergen.

BLS INTERVENTIONS

1. Recognize s/s of respiratory distress for age.
2. Reduce anxiety, assist patient to assume POC.
3. Oxygen administration as clinically indicated, (humidified oxygen preferred).
4. Assist patient with self-administration of prescribed Epinephrine device.

LIMITED ALS INTERVENTIONS - ADULT

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
2. Epinephrine (1:1,000) 0.3mg SQ. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
3. Nebulized Albuterol 2.5mg with Atrovent 0.5mg via handheld nebulizer for wheezing. May repeat times two (2).
4. Establish peripheral intravenous access. If patient's systolic blood pressure <90mm Hg, then given a bolus of 500ml normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.

LIMITED ALS INTERVENTIONS – PEDIATRIC (Less than 15 years of age)

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
2. Nebulized Albuterol 2.5 mg with Atrovent 0.5mg - may repeat times two (2).

- a. 1 Day to 12 months – Atrovent 0.25mg
- b. 1 year to 14 years – Atrovent 0.5mg
3. If no response to Albuterol and Atrovent, consider Epinephrine (1:1,000) 0.01mg/kg SC not to exceed adult dosage of 0.3mg. (with Base Station contact).
4. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20ml/kg of NS not to exceed 300ml NS and repeat as indicated.
5. Establish additional IV access if indicated.
6. Base Station may order additional medication dosages and additional fluid boluses.



OBSTETRICAL EMERGENCIES

UNCOMPLICATED DELIVERY

BLS INTERVENTIONS

1. Administer Oxygen as clinically indicated.
2. Prepare for delivery.
3. Massage fundus if placenta delivered.

COMPLICATED DELIVERY

BLS INTERVENTIONS

1. Excessive vaginal bleeding prior to delivery:
 - a. Attempt to contain bleeding. Do not place anything into vagina.
 - b. Trendelenburg position.
2. Prolapsed Cord:
 - a. Hips elevated.
 - b. Gently push presenting part of head away from cord.
 - c. Consider knee/chest position for mother.
3. Post Partum Hemorrhage:
 - a. Massage fundus to control bleeding.
 - b. Encourage immediate breast feeding.
 - c. Trendelenburg position.
4. Cord around infant's neck.
 - a. Attempt to slip cord over head.

- b. If unable to slip cord over head, deliver the baby through the cord.
 - c. If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps.
5. Breech presentation and head not delivered within 3-4 minutes:
- a. Hi-flow O₂ on patient.
 - b. Trendelenburg position.
 - c. Code 3 to closest appropriate facility.
6. Pregnancy induced hypertension and Eclampsia:
- a. Seizure precautions.
 - b. Attempt to reduce stimuli.
 - c. Limit fluid intake.
 - d. Monitor and document B/P.
 - e. Consider left lateral position.

LIMITED ALS INTERVENTIONS

1. Obtain IV access, and maintain IV rate as appropriate.
2. Excessive vaginal bleeding or post-partum hemorrhage.
 - a. Give fluid challenge of 500ml, if signs of inadequate tissue perfusion persist may repeat fluid bolus.
 - b. Maintain IV rate at 150ml/hr.
 - c. Establish 2nd large bore IV enroute.
3. Pregnancy Induced Hypertension / Eclampsia.
 - a. IV TKO, limit fluid intake.
 - b. Obtain O₂ saturation on room air, if possible.

- c. Place in left lateral position, and obtain BP after five (5) minutes.
4. Consider immediate notification of Base Station physician.



NEWBORN CARE

FIELD ASSESSMENT/TREATMENT INDICATORS

Field delivery with or without complications.

BLS INTERVENTIONS

1. When head is delivered, suction mouth then the nose, and check to see that cord is not around baby's neck.
2. Dry infant and provide warm environment. Prevent heat loss (remove wet towel).
3. Place baby in supine position at or near the level of the mother's vagina. After pulsation of cord has ceased double clamp cord at approximately 7" and 10" from baby and cut between clamps.
4. Maintain airway, suction mouth and nose.
5. Provide tactile stimulation to facilitate respiratory effort.
6. Assess breathing if respirations <20 or gasping, provide tactile stimulation and assisted ventilation if indicated.
7. Circulation:
 - a. Heart Rate <100 ventilate BVM with 100% O₂ for 30 seconds and reassess. Repeat if HR remains <100.
 - b. Heart Rate <60 begin chest compressions (rate 120 times/min) and provide BVM ventilation at a rate of 40-60 breaths/min with 100% O₂, reassess.
8. Central cyanosis is present, utilize supplemental O₂ at 10 to 15L/min using oxygen tubing close to infant's nose and reassess. If no improvement is noted after 30 seconds assist ventilation with BVM
9. Obtain Apgar scoring at one (1) and five (5) minutes. Do not use Apgar to determine need to resuscitate.

APGAR SCORE

SIGN	0	1	2
Heart Rate	Absent	< 100/minute	> 100/minute
Respirations	Absent	<20/irregular	>20/crying
Muscle Tone	Limp	Some Flexion	Active Motion
Reflex Irritability	No Response	Grimace	Cough or Sneeze
Color	Blue or pale	Blue Extremities	Completely Pink

LIMITED ALS INTERVENTIONS

1. Obtain vascular access via IV if indicated.
2. Obtain Blood Glucose by heel stick.
3. Contact Base Station if hypovolemia is suspected. Base Station may order 10-20ml/kg IV NS over 5 minutes. If unable to contact Base Station and transport time is extended give 10ml/kg IV NS over 5 minutes, may repeat.



SUSPECTED SUDDEN INFANT DEATH SYNDROME INCIDENT

PURPOSE

It is imperative that all prehospital personnel in ICEMA be able to assist the caregiver and local police agencies during a suspected SIDS Incident.

PROCEDURE

1. Follow individual department/agency policies at all times.
2. Ask open-ended questions about incident.
3. Explain what you are doing, the procedures you will follow, and the reasons for them.
4. If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
5. Provide the parent/caregiver with the number of the California SIDS Information Line:

1-800-369-SIDS (7437)

6. Provide psychosocial support and explain the emergency treatment and transport of their child.
7. Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.



TRAUMA - ADULT (15 Years of Age and Older)

Any critical trauma patient (CTP) requires expeditious packaging, communication and transportation to the most appropriate trauma hospital. In Inyo and Mono Counties, the assigned base station should be contacted. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030 AEMT

ADULT TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> • Assess environment and extrication as indicated • Ensure thorough initial assessment • Ensure patent airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Control obvious bleeding • Keep patient warm • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest most appropriate receiving hospital • Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances 	<ul style="list-style-type: none"> • Advanced airway as indicated <p>Unmanageable Airway: Transport to the closest most appropriate receiving hospital when the patient requires advanced airway:</p> <ul style="list-style-type: none"> • An adequate airway cannot be maintained with a BVM device <ul style="list-style-type: none"> • Apply AED • IV Access: Warm IV fluids when avail <p><i>Unstable:</i> BP<90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.</p> <p><i>Stable:</i> BP>90mmHG and/or signs of adequate tissue perfusion.</p> <p>Blunt Trauma:</p> <p><i>Unstable:</i> IV NS open until stable or 2000ml maximum is infused</p> <p><i>Stable:</i> IV NS TKO</p>

BLS Continued

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

Genital Injuries: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

Limited ALS Continued

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

- Administer IV NS 250ml bolus one time.

Impaled Object: Remove object upon trauma base physician order, if indicated.

<u><i>BLS Continued</i></u>	<u><i>Limited ALS Continued</i></u>
<p>Pregnancy: Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females \geq 24 weeks of gestation.</p> <p>Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.</p> <p>Determination of Death on Scene: Refer to Protocol # 12010 AEMT, Determination of Death on Scene.</p>	<p>Traumatic Arrest: Continue CPR as appropriate.</p> <ul style="list-style-type: none">• Monitor V-Fib or V-tach, defibrillate as per ACLS guidelines and ICEMA protocols. <p>Determination of Death on Scene: Refer to Protocol # 12010 AEMT, Determination of Death on Scene.</p> <p>-Severe Blunt Force Trauma Arrest: IF INDICATED: transport to the closest receiving hospital.</p> <p>-Penetrating Trauma Arrest: IF INDICATED: transport to the closest receiving hospital.</p> <ul style="list-style-type: none">• If the patient does not meet the “Obvious Death Criteria” in the “<i>Determination of Death on Scene</i>” Protocol #12010 AEMT, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.• Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact. <p>Precautions and Comments:</p> <ul style="list-style-type: none">○ Electrical injuries that result in cardiac arrest shall be treated as medical arrests.○ Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

	<p><u>Limited ALS Continued</u></p> <ul style="list-style-type: none">○ If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.○ Unsafe scene may warrant transport despite low potential for survival.○ Whenever possible, consider minimal disturbance of a potential crime scene. <p>Base Station Orders: May order additional:</p> <ul style="list-style-type: none">• fluid boluses.
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REFERENCE PROTOCOLS

**Protocol
Number**

9010 AEMT
10160 AEMT
10010/10020 AEMT
11070 AEMT
15030 AEMT
12010 AEMT

Protocol Name

General Patient Care Guidelines
Axial Spinal Stabilization
King Airway Device
Adult Cardiac Arrest
Trauma Triage Criteria and Destination Policy
Determination of Death on Scene



TRAUMA - PEDIATRIC (Less Than 15 Years of Age)

Any critical trauma patient (CTP) requires expeditious packaging, communication and transportation to the most appropriate trauma hospital. In Inyo and Mono Counties, the assigned base station should be contacted. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030

PEDIATRIC TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	LIMITED ALS INTERVENTIONS
<ul style="list-style-type: none"> • Assess environment and extrication as indicated • Ensure thorough initial assessment • Ensure patient airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Control obvious bleeding • Keep patient warm and reassure • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest most appropriate receiving hospital • Assemble necessary equipment for ALS procedures under direction of EMT-P and/or assemble pre-load medications as directed, excluding controlled substances. 	<ul style="list-style-type: none"> • Advanced airway as indicated <p>Unmanageable Airway: Transport to the closest most appropriate receiving hospital when the patient requires an advance airway: An adequate airway cannot be maintained with a BVM device.</p> <ul style="list-style-type: none"> • Apply AED • IV Access: Warm IV fluids when avail <p><i>Unstable:</i> Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access. o Administer 20ml/kg NS bolus IV, may repeat once.</p> <p><i>Stable:</i> Vital signs (age appropriate) and/or signs of adequate tissue perfusion. o <i>Maintain</i> IV NS rate at TKO.</p>

<u>BLS Continued</u>	<u>Limited ALS Continued</u>
<p>MANAGE SPECIAL CONSIDERATIONS:</p> <p>Abdominal Trauma: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.</p> <p>Amputations: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.</p> <ul style="list-style-type: none">• Partial amputation: Splint in anatomic position and elevate the extremity. <p>Blunt Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.</p> <p>Flail Chest: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.</p> <p>Fractures: Immobilize above and below the injury. Apply splint to injury in position found except:</p>	<ul style="list-style-type: none">• Transport to appropriate hospital: PEDS patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closes trauma hospital. <p>MANAGE SPECIAL CONSIDERATIONS:</p> <p>Fractures:</p> <p>Isolated Extremity Trauma: Trauma <u>without multisystem mechanism.</u></p>

BLS Continued

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

Genital Injuries: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

Limited ALS Continued

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

- Administer 20ml/kg NS bolus IV one time.

- Base Station Orders:

BLS Continued

Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

Pediatric Patients: If the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.

Determination of Death on Scene: Refer to Protocol # 12010 AEMT, Determination of Death on Scene.

Limited ALS Continued

Impaled Object: Remove object upon trauma base physician order, if indicated.

Traumatic Arrest: Continue CPR as appropriate.

- Apply AED follow instructions.

Determination of Death on Scene: Refer to Protocol # 12010 AEMT, Determination of Death on Scene.

-Severe Blunt Force Trauma Arrest:
IF INDICATED: transport to the closest receiving hospital.

-Penetrating Trauma Arrest:
IF INDICATED: transport to the closest receiving hospital.

- If the patient does not meet the "Obvious Death Criteria" in the "Determination of Death on Scene" Protocol #12010 AEMT, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

	<p><u>Limited ALS Continued</u></p> <ul style="list-style-type: none"> • Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact. <p>Precautions and Comments:</p> <ul style="list-style-type: none"> ○ Electrical injuries that result in cardiac arrest shall be treated as medical arrests. ○ Confirm low blood sugar in children and treat as indicated with altered level of consciousness. ○ Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment. ○ Unsafe scene may warrant transport despite low potential for survival. ○ Whenever possible, consider minimal disturbance of a potential crime scene. <p>Base Station Orders: May order additional:</p> <ul style="list-style-type: none"> • fluid boluses.
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Protocol Number

9010 AEMT
10160 AEMT
10010/10020 AEMT
14040 AEMT
15030 AEMT
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Protocol Name

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